# Chapter One

# Introduction

**Sociology of Health, Illness and Health Care**

Sociology, as an academic discipline, is concerned with the social causes and consequences of human behavior. Thus, it follows that medical sociology is concerned with the social causes and consequences of health and illness. Recognition of the significance of the complex relations between social factors and the level of health characteristic of various groups and societies has led to the development of medical sociology.

Medical sociology brings sociological perspectives/theories, and methods to the study of health, illness, and medical practice. The sociology of health ranges over a wide territory, including:

- the  social facets of health and disease
- the social behavior of health care personnel and their clients (physician-patient relationships)
- the social functions of health organizations and institutions
- the social patterns of health services, and the relationship of health care delivery systems to other systems such as the economy and politics (or the organization and structure of health organizations and the socio-economic basis of the health care system)
- the social aspects of physical and mental illness
- how some conditions come to be called diseases and the experience of being sick/ill
- the organization of the medical profession
- the ways in which health policies are produced; and the workings of hospitals and other health centers.

According to R. Weitz (2004), sociologists of health, illness, and health care can study diverse range of topics, including:

**First,** sociologists can study how social forces promote health and illness and why some social groups suffer more illness than others do. Sociologist can study how historical changes in patterns of social life can explain changes in patterns of illness. For example, to understand why rates of breast cancer have increased, some researchers have studied the impact of women's changing social roles, and others have studied the impact of political forces that promote increased meat consumption.

**Second,** instead of studying broad pattern of illness, sociologists can study the experiences of those, who live with illness on a day-to-day basis – exploring, for example, how illness affects individuals' sense of identity, relationships with family, or ideas about the causes of illness.

**Third,** sociologists can focus on the impact of social factors on health care providers. For example, some sociologists have analyzed how the status and power of different occupations have shifted over time, and other have investigated how power affect interactions between health care occupations (such as doctors and nurses). Still others have examined interactions between health care workers and patients, asking, for example, how doctors can maintain control in their discussions with patients or whether doctors treat male and female patients differently.

**Finally,** sociologists can analyze the health care system as a whole. Sociologists have examined how health care systems have developed, compared the strengths and weaknesses of different systems, and explored how systems can be improved. For example, some have studied how and why health insurance companies sometimes make it difficult for people – who needed care – to get the needed care.

## 1.1 The Development of Medical Sociology

Unlike law, religion, politics, economics and other social institutions, medicine was ignored by sociology's founders in the late nineteenth century because it did not appear to shape the structure and nature of society. Karl Marx's collaborator Friedrich Engles linked the poor health of English working class to capitalism in a treatise published in 1845, and Emile Durkheim analyzed European suicide rates in 1897. However, Durkheim, Marx, Max Weber and other major classical theorists did not concern themselves with the role of medicine in society. Medical sociology did not emerge as an area of study in sociology until the late 1940's and did not reach a significant level of development until the 1960s. Therefore, the field developed relatively late in the evolution of sociology as an academic subject and lacked major statements on health and illness from the classical theorists.

Medical sociology was established as a specialized field in the United States during the 1940's. The first use of the term *medical sociology* appeared as early as 1894, in a medical article by Charles McIntire on the importance of social factors in health. Other early work included essays on the relationship between medicine and society in 1920 by Elizabeth Blackwell, the first woman graduate from medical school in America and James Warbasse in 1909. However, these early publications were produced by people more concerned with medicine than sociology and it remained for Bernard Stern to publish the first work from a sociological perspective in 1927, titled Social Factors in Medical Progress. Medical sociology did not

begin in earnest until after World War II, when significant amount of federal funding for socio-medical research first became available. Under the auspices of the National Institute of Mental Health, medical sociology's initial alliance with medicine was in psychiatry. A particularly significant cooperative effort that followed was the publication in 1958 of Social Class and Mental illness: A Community Study by August Hollingshead and Frederick Redlich. This landmark research, conducted in New Haven, Connecticut, produced important evidence that social factors could be correlated with different types of mental disorders and the manner in which people received psychiatric care. Persons in the most socially and economically disadvantaged segments of society were found to have the highest rates of mental disorder in general and excessively high rates of schizophrenia-the most disabling mental illness-in particular. This study attracted international attention and is the best-known single study in the world of the relationship between mental disorder and social class. This book played a key role in the debate during the 1960s, leading to the establishment of community mental health centers in the United States,

After the close of World War II, the expansion of the National Institutes of Health and the interest of private foundations in interdisciplinary research stimulated and supported the growth of medical sociology as an area of research and teaching. During the 1950s, the field developed in two directions: sociology of medicine, centered in departments of sociology in universities, and sociology in medicine, concentrated in schools of medicine and health care facilities.

According to the analysis given by Robert Straus the sociology *in* medicine is one who collaborates directly with the physician and other health personnel in studying the social factors that are relevant to a particular health disorder. The work of the sociologist in medicine is intended to be directly applicable to patient care or to the solving of a public health problem. Some of the tasks are to analyze the social etiology or causes of health disorders, the differences in social attitudes as they relate to health and the way in which the incidence and prevalence of a specific health disorder is related to such social variables as age, sex, socioeconomic status, racial/ethnic group identity, education and occupation. Such an analysis is then intended to be made available to health practitioners to assist them in treating health problems. Thus, sociology in medicine can be characterized as *applied research and analysis primarily motivated by a medical problem* rather than a sociological problem. Sociologists in medicine usually work in medical schools, nursing schools, public health schools, teaching hospitals, public health agencies and other health organizations.

The sociology *of* medicine, however, has a different emphasis. It deals with such factors as the organization, role relationships, norms, values and beliefs of medical practice as a form of human behavior. The emphasis is on the social processes that occur in the medical setting and how these contribute to our understanding of medical sociology in particular and to our understanding of social life in general. The sociology of medicine shares the same goals as all other areas of sociology and may consequently be characterized *as research and analysis of the medical environment from a sociological perspective*. Most sociologists of medicine are employed as professors in the sociology departments of universities and colleges.

**A Critical Approach**

Although the concept of power underlies the sociological perspective, some sociologists do not emphasize power in their research and writing. Instead, some sociologists essentially take for granted the way power is distributed in our society, examining the current system without questioning why it is this way or how it might be changed. For example, some sociologist have investigated whether lower-class persons are more likely than upper-class persons to suffer mental illness without first questioning whether definitions of mental illness might reflect an upper class perspective regarding socially acceptable behaviors or whether the same behaviors might more likely be defined as symptoms of mental illness when performed by lower-class persons.

Those sociologists, on the other hand, who do not take for granted existing power relationships and who instead, focus on the sources, nature and consequences of power relationships can be said to use a critical approach. Critical sociologists recognize that, regardless of how power is measured, men typically have more power than women, adults have more power than children, whites have more power than African Americans, heterosexuals have more power than gays and lesbians, persons with socially acceptable bodies have more power than persons who are disabled, and so on. Critical sociologists who study health, illness and health care have raised such questions as how this differential access to power affects the likelihood that members of a social group will be exposed to illness-producing conditions or will have access to quality health care.

Critical sociologists also emphasize how social institutions and popular beliefs can support or reflect existing power relationships. For example, many researchers who study the U.S. health care system have looked simply for ways to improve access to care or quality of care within that system, such as offering poor people subsidized health insurance or providing financial incentives to doctors who practice in low-

income neighborhoods. Those who use a critical approach have asked instead whether we could provide better care to more people if we changed the basic structure of the system, such as by removing the profit motive from health care to reduce the costs of care for everyone. Similarly, critical sociologists have drawn attention to how doctors' power and authority enable them to frame our ideas about health, illness and health care. Most basically, these sociologists have questioned the very terms health, illness and disability and have explored whether such terms reflect social values more than they reflect objectively measurable physical characteristics.

In any sociological field, therefore, those who adopt a critical approach will ask quite different research questions from those who do not. Within the sociology of health, illness and health care, this translates in large part into whether sociologists limit their research to questions about social life that doctors consider useful — a strategy referred to as **sociology in medicine** — or design their research to answer questions of interest to sociologists in general — a strategy referred to as the **sociology of medicine** (Straus, 1957). Research using the latter strategy often challenges both medical view of the world and existing power relationships within health care.

To understand the difference between sociology in medicine and sociology of medicine, consider the sociological literature on patients who do not follow their doctors' advice. Because doctors typically define such patient as problems, over the years many sociologists, accepting medical ideas regarding what questions need asking, have sought to determine how to "bring patients to their senses" and increase their compliance with medical advice. In contrast, sociologists of medicine have looked at the issue of compliance through patients' eyes. As a result, they have learned that patients sometimes ignore medical advice not out of stubbornness or foolishness but because their doctors have not explained clearly either how to follow the prescribed regimens or why they should do so. In other circumstances, patients have ignored medical advice because they have concluded rationally that the emotional or financial costs of doing so outweigh the potential medical benefits. Similarly, whereas those practicing sociology in medicine have studied various aspects of the experience of patient-hood, those practicing sociology of medicine instead have studied the broader experience of illness, which includes but is not limited to the experience of patient-hood. The growing emphasis on sociology of medicine and on the critical approach has led to a proliferation of research on the many ways illness affects everyday life and on how ill individuals, their families and their friends respond to illness.

*Some of Key Concepts in Medical Sociology*

- **Health** is defined (WHO) as complete Physical (anatomic-physiological), mental (behavioural, cognition, learning, and thinking), emotional (affection), social (interactions as well as coping with the human surrounding), spiritual, etc. wellbeing and not just the mere absence of a given disease condition or infirmity.

- **Sociology in medicine** refers to applied research and analysis…..primarily motivated by a medical problem rather than a sociological problem. Whereas **Sociology of medicine** is meant to research and analysis of the medical environment from sociological perspective. Design the research to answer questions of interest to sociologists.

- **Epidemiology** studies the social distribution and social determinants of states of health. It is the study of the distribution of disease within a population. It is the branch of medicine that deals with the incidence, distribution, and possible control of diseases and other factors relating to health.

- **Social epidemiology** is the distribution of disease within a population according to social factors (such as social class or use of tobacco) rather than biological factors (such as blood pressure or genetics).

- **Epidemiological transition** refers to the shift from a society characterized by infectious and parasitic diseases and low life expectancy to one characterized by degenerative and chronic diseases and high expectancy.

- **Rate** refers to the proportion of a specified population that experiences a given circumstance. Two particularly useful types of rates are incidence and prevalence rates.

- **Incidence** refers to the number of new occurrences of an event (disease, births, deaths and so on) within a specified population during a specified time period. Incidence better measures the spread of acute illnesses which strike suddenly and disappear quickly and rapidly spreading diseases such as AIDS.

- **Prevalence** refers to the total number of cases within a specified population at a specified time—both those newly diagnosed and those diagnosed in previous years but still living with the condition under study. Prevalence better measures the frequency of chronic illnesses, which last for many years, such as muscular dystrophy, asthma and diabetes.

- **Morbidity** refers to symptoms, illnesses and impairments; **mortality**, on the other hand refers to deaths. Both of them often used in epidemiology are morbidity and mortality.

- **Epidemic** refers to any significant increase in the numbers affected by a disease or to the first appearance of a new disease. **Pandemics** also worldwide epidemics. Whereas, **endemic** refers to a long-term established diseases within the population so they maintained a fairly stable prevalence.

- **Chronic Illness:** illness that develops in an individual gradually or is present from birth and that will probably continue at least for several months and possibly until the person dies. Examples include muscular dystrophy, asthma, and diabetes. **Acute illness,** on the other hand, refers to any illness that strikes suddenly and disappears rapidly (within month or so). Example includes chickenpox, colds, and influenza.

- **Inpatient:** hospital patient who is formally admitted or kept overnight. Whereas **outpatient** refers to hospital patient who is neither neither formally admitted nor kept overnight.

- **Health care** is a reaction to symptoms and illness which involves decisions on appropriate treatment for a patient that has ranges of possibilities where patients deal with the symptom themselves to obtaining professional help. Health care includes: 1) **Primary care**, taking place in the community as a point of first contact; 2) **Secondary care**, usually taking place in hospitals and delivered by specialists; and 3) **Tertiary care** is sometimes used to indicate rehabilitation, or restorative rather than curative care.

- Prevention
    - **Tertiary prevention**: strategies designed to minimize physical deterioration and complications among those already ill.
    - **Secondary prevention**: strategies designed to reduce the prevalence of disease through early detection and prompt intervention.
    - **Primary prevention**: strategies designed to keep people from becoming ill or disabled, such as discouraging drunk driving, lobbying for stricter highway safety regulations, and promoting vaccination.

- **Medicalization** describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness or disorders. It also refers to the process of labeling social and emotional phenomena as medical, which by consequence, ask for medical intervention and solution.

- **Disease, Illness and Sickness: Disease** refers to a biological problem within an organism. It refers to the doctor's perspective on ill-health. **Illness**, on the other hand, refers to the social

experience and consequences of having a disease. It reflects the patient's perspective (the emic approach). **Sickness** is the social role attached to a health problem by the society at large. It refers to the influence of the society-at-large on illness and the individual suffering from ill-health. Sick individuals are designated a different social role than the healthy: often they are exempted from work and other social responsibilities.

- **Health behavior** is the behavior or the lifestyle of healthy people. It is defined as the activity undertaken by individuals for the purpose of maintaining and/or enhancing their health, preventing health problems, or achieving a positive body image .

- **Illness behavior** where by a person who feels ill is engaged in some activities for the purpose of defining that illness and seeking relief from it. It is the behavior of people who feel sick and are in need of medical treatment.

- **Health lifestyles** are collective patterns of health related behavior based on choices from options available to people in line with their life chances. A person's life chances are largely determined by his or her class position that either enable or constrain health lifestyles choices.

- **Self-care** is the most common response to symptoms of illness by people includes taking preventive measures like Consuming vitamin supplements, Self-treatment of symptoms (such as taking home remedial or over-the counter drugs), Managing chronic conditions (for instance, use of insulin by a diabetic) and consultant with health care providers and use of their services. It is essentially consists of a layperson's preventing, detecting, and treating his or her own health problems.

- **The sick role**: According to Parsons, there are normative responses by societal members when they are sick. He calls these patterns of behavior expected of the sick person the sick role. The sick role is a pattern of behavior that defines what is expected of and appropriate for people who are ill.

- **Medicaid**: the state or government-funded health insurance program that pays the costs of health care for people with incomes below a certain (very low) amount. **Medicare**, on the other hand, refers to federal insurance, based on the social security system that offers hospital insurance and medical insurance to those over age of 65 and to permanently disabled persons.

# Chapter Two: Medicalization or Medicine as Social Control

**Creating Illness: Medicalization**

The process through which a condition or behavior becomes defined as a medical problem requiring a medical solution is known as medicalization (Conrad and Schneider, 1992). For example, as social conditions have changed, activities formerly considered sin or crime, such as masturbation, homosexual activity, or heavy drinking, have become defined as illness. The same has happened to various natural conditions and process such as uncircumcised penises, aging and the entire life course of the female reproductive system, from menstruation, to pregnancy and childbirth, to menopause (for example, Figert, 1996; McCrea, 1983; Sullivan and Weitz, 1988). Medicalization doesn't simply happen, rather, it is the end stage in a series of events. For medicalization to occur, one or more organized social group must have both a vested interest in working toward the end and sufficient power to convince others (including **doctors, the public and insurance companies**) to accept their new definition of the situation.

Not surprisingly, **doctors** often play a major role in medicalization, because medicalization can increase their power, the scope of their practices, and as a result, their incomes. For example, during the first half of the twentieth century, improvements in the standard of living coupled with the adoption of numerous public health measures substantially reduced the number of seriously ill children. As a result, the market of pediatrician declined and their focus shifted from treating serious illnesses to treating minor child hood illness and offering well-baby care. Consequently, pediatrics becomes a less remunerative, interesting, and prestigious field. To increase their market while obtaining more satisfying and prestigious work, some pediatricians have expanded their practices to include children whose behavior concerned their parents or teachers and who are now defined as having medical zing premenstrual syndrome (Figert, 1996), drinking during pregnancy (Armstrong, 1998), impotence (Tiefer, 1994), and numerous other conditions. **In other instance, however, doctors have indifferent or even opposed to medicalization.** For example, although some doctors believe that woman battering in a medical problem and the doctors should accept responsibly for identifying it and intervening when it occurs, others believe that women provoke their own battering, that doctors can do little to help, or that women battering is best dealt with by the police rather than by doctors (Kurz, 1987). As a result, many doctors oppose medicalizing woman battering and prefer to treat woman's injuries without delving into their causes.

In circumstances such as these, pressure for medicalization can instead come from **lay groups**. Alcoholics Anonymous, for example, has fought to medicalize alcoholism partly as means of relieving alcoholics from some of the stigma of their addiction. Other lay groups similarly have argued for medicalization in the hope that medical control will be more humanitarian than legal control, in such areas as compulsive gambling, erratic and violent behavior, and homosexuality. In addition, individuals might press for medicalization and a way of gaining validation for their experience and stimulating research on treatment and cures (Ziporyn, 1992). For example, much of the pressure to define premenstrual syndrome and chronic fatigue syndrome as illness has come from persons who believe they suffer from these syndromes.

The third major force behind medicalization is the **pharmaceutical industry**. This industry has a vested economic interest in medicalization whenever it can provide a drug as treatment. The medicalization of shortness exemplifies this process (Werth, 1991). In 1985, the pharmaceutical company Genentech patented a genetically engineered and mass produced form of human growth hormone (HGH). At that time, the available data suggested that HGH could increase final height in children whose pituitary glands did not naturally produce enough HGH, but could not increase final height in children without pituitary defects. Moreover, it was known that HGH could promote a drastic loss of bodies of growing children. Nevertheless, Genetic and, subsequently, Elli Lilly pharmaceuticals (which patented a slightly different synthetic hormone) embarked on a major campaign to sell HGH. Together, they underwrote two-thirds of the budget of the human Growth Foundation, a nonprofit advocacy group that works to increase public awareness of the problems experienced by short children. With the pharmaceutical companies also began broadcasting news of HGH across the nation of health fairs, shopping malls, and the like. The pharmaceutical companies also began spending millions of dollars annually to underwrite medical research supporting HGH, to advertise the drug to doctors, an to sponsor in-school screening programs that identified children in shortest 3 % of the population and informed their parents that the children had a disease requiring medical treatment.

By 1999, about 30,000 children - 20 percent of whom have no disease other than shortness-were being treated with HGH in the united states, at an average cost per child of about $ 25,000 yearly for an average of ten years (Greenberg, 19990). According to the only long-term study (partially funded by Genentech) of the drug's effectiveness and potential for long-term health problems (such as tumors and diabetes) and because identifying short children as "diseased" and treating them with daily injections

over several years can lead to social stigma and lowered self-esteem, the America academy of pediatrics (1997) currently recommends against its use in short but otherwise healthy children.

**The Consequences of Medicalization**

In some circumstances, medicalization can be a boon, leading to increased social awareness of a problem, sympathy toward its sufferers, and the development of beneficial therapies. Persons with epilepsy, for example, lead far happier and more productive lives now that drugs usually can control their seizures and that few people view epilepsy as a sign of demonic possession. Yet as the previously discussed examples suggest, it also can produce unintended negative consequences (Conrad and Schneider, 1992; Zola, 1972).

**First,** defining a condition as an illness does not necessarily improve the social status of those who have that condition. Those who use alcohol excessively, for example, continue to experience social rejection despite the medicalization of alcoholism.

**Second**, once a situation becomes medicalized, doctors become the only experts considered appropriate for responding to it, increasing the power of doctors at the expense of other social groups. With the medicalization of troublesome behavior in children, for example, the voices of parents, teacher, and the children themselves have lost credibility when they disagree with doctors' assessments.

**Third**, once a condition is medicalized, medical treatment becomes the only logical response to it. For example, if women's battering is considered a medical condition, then doctors need to treat women and the men who batter them. However, if women's battering is considered a social problem stemming from male power and female subordinating, then it makes more sense to arrest the men, assist the women in developing financial and emotional independence, and work for broader structural changes that will increase all women's status and options. **Medicalization** can justify not only voluntary treatment. Yet treatment does not always help and sometimes can harm. For example, around the country during the last two decades, U.S court have forced women to submit to cesarean deliveries, in which babies are surgically removed from their mother's uteruses rather than delivered naturally through the vagina (Daniels, 1993). In these cases, doctors argued successfully that childbirth is a dangerous medical condition, not a natural process, and that therefore mothers lack the expertise to decide whether cesarean deliveries are in their and their babies best interests. Yet doctors' judgment is not infallible. A 1987 study found that in six of the first fifteen cases in which doctors sought court orders to force cesarean deliveries, the mothers in the end delivered healthy babies vaginally (Kolder et al., 1987); the remaining nine women were forced to have cesareans, so we can not know whether they might have safely

delivered vaginally. Moreover, the rate of cesarean deliveries in the united state is about twice that recommended by the World Health Organization (1985:437), suggesting the U.S. doctors are far too ready to perform this potentially life-threatening surgery. The ethical issues involved in forced obstetrical interventions, and the broad issue of "fetal rights."

**Fourth,** and as these examples suggest, medicalization significantly expands the range of life experiences under medical control. For example, the existence of "fetal alcohol syndrome" – a constellation of birth defects including mental retardation believed caused by drinking alcohol during pregnancy – was widely accepted by American doctors based on three articles: two case studies describing a total of 11 cases born to women who were chronic alcoholics and one retrospective study that found six cases out of 55,000 patient records in which doctors had symptoms now considered possible indicators of fetal alcohol syndrome (Armstrong, 1998). None of these studies controlled for other variable or used random Sample and none gave data suggesting a widespread problem, even among severe alcoholics. Yet based on these articles, and the very limited additional data that has been collected since then, doctors and others have campaigned to forbid restaurants and bars from serving alcohol to pregnant women; to require liquor manufacturers, restaurants, and bars to post warning labels and signs warning of the dangers of drinking during pregnancy; and to jail or hospitalize involuntarily women who drink during pregnancy. Similarly, through defining tobacco use and overweight as risk factors for illness and, at times, as illnesses in themselves, doctors have laid the ideological groundwork for employers to discriminate against smokers and overweight persons. Using this medical rhetoric, some corporations now justify firing or refusing to hire smokers and overweight persons on the grounds that they are more likely to perform poorly, become ill, or drive up the company's health insurance rate (Brandt and Rozin, 1997; Nelkin and Tancredi, 1989). This expansion of medical control over broad areas of life diminishes the power of other social authorities, including judges, the police, religious leaders, legislators, and teachers. Through medicalization, questions such as who should receive experimental but potentially life-saving surgery becomes defined as strictly medical, rather than social, religious, economic or ethical issues.

**Fifth,** medicalization can hide the political nature of social actions. For example, both china and the former Soviet Union removed many political dissidents from the public eye by committing them to mental hospitals. By so doing, these governments discredited and silenced individuals who might otherwise have offered powerful dissenting voices. In other words medicalization allowed these governments to **depoliticize** the situation – to define it as a medical rather than a political problem.

Similarly, medicalizing woman battering encourages a limited focus on the behavior and personality of individual men and women rather than on the social and political force that give men the power to beat women and deny women the power to leave their abusers.

**The Rise of Demedicalization**

The dangers of medicalization have fostered a countermovement of demedicalization (Fox, 1977). A quick look at medical textbook from the late 1800s reveals many "diseases" that no longer exist. For example, 19th century medical textbooks often included several pages on the health risks of masturbation. One popular text book from the late nineteenth century asserted that masturbation caused "extreme emaciation, sallow or blotched skin, sunken eyes, … general weakness, dullness, weak back, stupidity, laziness …wandering and illy defined pains," as well as infertility, impotence, consumption, epilepsy, heart disease, blindness, paralysis, and insanity (Kellogg, 1880:365). Today, however, medical textbooks describe masturbation as a normal part of human sexuality.

**Like medicalization, demedicalization often begins with lobbying by lay group**. For example, medical ideology now defines childbirth as an inherently dangerous process, requiring intensive technological, medical assistance. Since the 1940s however, growing numbers of American women have attempted to redefine childbirth as a generally safe, simple, and natural process and have promoted alternatively ranging from natural childbirth class, to hospital birthing centers, to home births assisted only by midwives (Sullivan and Weitz, 1988). Similarly, gay and lesbian activists have at least partially succeeded in defining homosexuality from a pathological condition to a normal human variation. More broadly, in recent years, books, magazines, television shows, and popular organizations devoted to teaching people to care for their own health rather than relying on medical care have proliferated. For example, in the early 1970's the Boston Women's Health Book Collective published a 35-cent mimeographed booklet on women's health. From this, they have built a virtual publishing empire, which has sold millions of books to consumers worldwide on childhood, adolescence, aging and women's health, including the best-selling Our Bodies, Ourselves.

# Chapter Three: Sociological Theories/Perspectives on Medical Sociology

The three major theories include structural functionalism, conflict, and symbolic interactionism.  In order to make sense of the issues and facts of health and medicine, the first two theories will look at the structural aspects while the third one analyses health and illness at micro-level.

**Functionalism**

It envisions society as made up of a complex system whose parts work together with the goal of promoting solidarity and stability. In line with these, the pioneer sociological work from this perspective was contributed by Talcott Parsons in 1951 when he argued and viewed medicine as a strategy devised by a society to keep its members healthy. Hence, illness is dysfunctional that undermines the performance of social roles and eventually impedes the operation of society.

*The sick role:* According to Parsons, there are normative responses by societal members when they are sick. He calls these patterns of behavior expected of the sick person the sick role. The sick role is a pattern of behavior that defines what is expected of and appropriate for people who are ill. This role releases ill people from normal obligations such as going to work or attending classes. But in order to prevent the misuse of this privilege people cannot simply claim to be ill and in serious cases medical experts will assist in attesting. Moreover, once the sick role is assumed, the patient must want to get better and must do all the necessary activities to regain good health including cooperating with health professional.

*The Physician's Role:* Physicians play important role to evaluate people's claims of sickness and help restore to the normal regular activities. In the process physicians use their specialized knowledge, expect the cooperation of patients in providing the necessary information and following the orders of a doctor to complete the treatment.

According to functionalism theorists, Illness may not entirely be dysfunctional and may have some positive consequences. This occurs when people who experience serious illness find it provides the opportunity to reevaluate their lives and gain a better sense of what is really important in their life.

**Symbolic Interactionism**

*The Social Construction of Illness:* For symbolic interaction proponents society is less a grand system and health and medical care are socially constructed by people in everyday interaction. By implication, if both health and illness are socially constructed, people in a poor society may view hunger and malnutrition as normal. Moreover, how people define a medical situation may actually affect how they feel. Medical experts marvel at psychosomatic disorders that fusses mind and body where state of mind guides physical sensations.

*The Social Construction of Treatment:* Erving Goffman dramaturgical approach explains how physicians tailor their surroundings including their offices and their behavior so that others see them as competent and in charge. This explanation of Goffman could be further illustrated by the process of

reality construction of treatment when a woman undergoes the gynecological examination carried out by a male doctor. The situation is susceptible to misinterpretation because a man's touching of a woman's genital is conventionally vied as a sexual act and possibly an assault. Nonetheless, to make sure that people define the situation or examination and treatment as impersonal, the medical staff wears uniforms and furnishes the room with medical equipment. Moreover, the manner of the doctor and overall performance are designed in such a way to make the patient feel the examination of the genital area is no different for the doctor from treating any other parts of the body. To strengthen this assumption, a female nurse may be present during the examination and treatment not only to assist the physician but also to avoid the expression that a man and a woman are alone in a room.

***The Social Construction of Personal Identity:*** Symbolic interaction also gives insights into how surgery can affect people's social identity. The reason why medical procedures can have significant effect on how we think of ourselves is due to the fact that some organs and other parts of the body have cultural importance.

In general, what people view as healthful or harmful depends on a number of factors from symbolic interaction perspective. These factors are not all in all medical factors. The medical procedure also brings the patient and the medical staff together and they construct the medical reality of that situation.

## Social Conflict and Feminist Analysis

The social conflict analysis tries to link health and social inequality by taking a cue from Karl Marx and ties medicine to the oppression of capitalism. Researchers from social conflict perspective focus on three major issues: access to medical care, the effects of profit motive, and the politics of medicine.

***Access to Care:*** Health is important for every person. But access to medical care may not be equally possible for every person. The core of the argument here is that when individuals are required to pay for medical care in capitalist societies it would be the richest people who are going to have the best health. Access to health becomes a more serious problem when there is no universal coverage of basic health service.

***The Profit Motive:*** Some conflict theorists take the analysis a step further and argue the real problem is not access to medical care. Instead, the problem lies in the character of the capitalist medicine itself. The capitalist system being driven by profit motive turns physician, hospitals, and the pharmaceutical industry into multimillion dollar corporations. This quest for profit encourages physicians to recommend unnecessary tests and surgery and to rely too much on drugs rather than focusing on improving people's living conditions and lifestyles. Therefore, the decision to perform surgery

according to social conflict theory reflects the financial interest of surgeons and hospitals as well as the medical needs of patients. The theorist also criticizes members of a society for too tolerant of physicians' having a direct financial interest in the tests and procedures they order for their patients. Finally, the social conflict scholars suggest that medical care should be motivated by a concern for people and not profit.

*Medicine as Politics:* conflict theorists argue that scientific medicine explains illness exclusively in terms of bacteria and viruses ignoring the damaging effects of poverty. Medicine hides the bias in contemporary medical system by transforming this social issue into simple biology. In a nutshell, social conflict analysis is another sociological view of the relationship among health, medicine, and society. It has been stipulated that social inequality is the reason for some people to better health than others.

**Labeling Theory**

The failure of the sick role among other things is the fact that two people having much the same symptoms may behave quite differently. One person may become concerned and seek medical treatment while the other person may ignore the symptom completely. Therefore, labeling theory is based on the idea that what is regarded as deviant behavior by one person or social group may not be regarded so by other persons or social groups. An important illustration on labeling theory was provided by Howard Becker in which the research reveals the discrepancy in American society between those people who insist that smoking marijuana is harmful and the use of drug should be illegal, and those who support a norm favoring marijuana smoking and who believe that use of the drug should be legalized. In other words, while the wider society views marijuana smoking as deviant, the groups of marijuana smokers view their behavior as socially acceptable within their own particular group.

Labeling theory approaches illness behavior in such a way that while disease may be a biological state existing independently of human knowledge, sickness is a social state created and formed by human perceptions. For instance, skin disease and injuries to the skin are common because of the difficult jungle environment among the Kuba people of Sumatra. Hence, a person suffering from skin disease would not be considered to be sick among the Kuba because although the condition is unhealthy, it is not considered abnormal. The judgment concerning what is sickness and what is deviant behavior are relative and cannot be separated from the social situations in which people live. However, labeling theory suffers from vagueness in its conceptualization, namely what causes deviance other than societal reaction-which has little or nothing to do with disease.

**Max Weber: Lifestyles**

Weber is one of the most influential sociological theorists of all time, and his views on lifestyles in general help place the concept of a "healthy lifestyle" in perspective. His notion of lifestyles appears in his discussion of status groups in his classic work Economy and Society, originally published in 1922. One's lifestyle is a reflection of the types and amounts of goods and services one uses or consumes, thus, for Weber, the difference between status groups does not lie in their relationship to the means of production as suggested by Marx, but in their relationship to the means of consumption.

Status group refers to people who share similar material circumstances, prestige, education and political influence. Moreover, members of the same status group share a similar lifestyle. A particular lifestyle is what distinguishes one status group from another. People with high SES clearly lead a different style of life than those at the bottom of society and those somewhere in the middle. Karl Marx argued that class position influences lifestyle. However, Max Weber made important observations in that lifestyles are not based upon what one produces but upon what type of goods and services one consumes i.e. the level of consumption.

After analysis of the relationship between class and social status, Weber deliberately used three terms to express his view of lifestyle, including: *Lebensstil* (lifestyle), *Lehenfzihrung* (life conducts), and *Lebenschancen* (life chances). Weber suggested that the last two are components of lifestyle. Life conduct (*lebensfubrung),* refers to the choices that people have in the lifestyles they wish to adopt, but the potential for realizing these choices is influenced by their, *lebenschancen,* or life chances. So, the choices people have in the lifestyle they wish to adopt (life conduct) is influenced by the probability of acquiring financial resources status, rights and social relationships. One's socio-economic circumstances are therefore, one of the important factors that shape one's life chances.

Ralf Dahrendorf (1979) noted that Weber is ambiguous about what he really means by life chances, but the best interpretation he found is that life chances (*lebenschancen)* are the "probability of finding satisfaction for interests, wants and needs". For Weber, the notion of life chances therefore refers to the probability of acquiring a particular lifestyle, which means the person must have the financial resources, status, rights, and social relationships that support the chosen lifestyle. One's life chances are shaped by one's socioeconomic circumstances.

According to Cockerham (2007), Weber's ideas about lifestyles are important for several reasons:

- His work led to the development of the concept "socio-economic status: SES" in sociology as the most accurate reflection of a person's social class position. The location of a person in the

social hierarchy of a society is determined not by income alone but by three indicators such as income, education and occupation.

- Lifestyle is a reflection of a person's status in society and lifestyles are based on what people consume rather than produce.

- Lifestyles are based upon choices but these choices are dependent on the individuals' potential for realizing them. These potential is usually determined by the person's socio-economic circumstances.

- Although particular lifestyle characterizes particular socio-economic groups, some lifestyle spread across class boundaries and gain wider influence on the wider society. Therefore, in relation to health lifestyles, Weber's work suggest that while such lifestyles are oriented towards producing health, the aim of the activity is ultimately towards its consumption as people try to be healthy so they can use their health to live longer, enjoy life , be able to keep on working and so forth. The lower class viewed health largely as a means to an end (work), while persons with higher SES regarded health as end in itself (vitality and enjoyment).

*Poor and health:* There are differences among socio-economic groups in relation to health lifestyles. In spite of the tendency for many people especially in modern society to adopt health life styles within the limits of their circumstances, the poor are disadvantaged in relation to positive health lifestyles. This is attributed partly to the fact that socially disadvantaged individuals have less access to health information, and resources, have less control over sleeping hours as well as food choices. They are more likely to live in a social environment where unhealthy eating, smoking and heavy drinking are normality and all these factors make the formation of risky lifestyles possible.

**Pierre Bourdieu: Health Lifestyles**

A seminal study conducted by Pierre Bourdieu in 1984 shades lights on the relationship between social class and lifestyles. Bourdieu investigated class, competition and reproductions as expressed in cultural tastes and styles. The study analyzed how eating habitus and sport preferences or class based set of durable dispositions to act in particular ways shaped particular facets of health lifestyles.

The study showed that people from the same social class tended to share the same or similar habitus since they have similar life chances. For example, working class enjoyed soccer, while people in the professionals (upper and middle class) liked tennis or Golf. As for food, the working class typically favored foods that were cheap, nutritious, and abundant, while professional people were more concerned about body image and opted for foods that were light tasty, and low in calories. The other useful point

from the study conducted by Bourdieu was the notion of distance from necessity which was used as the key explanation of class differences in lifestyles. In this regard, he found that the more distant a person from foraging for economic necessity , the more freedom and time that person has to develop and refine personal tastes in line with a more privileged class status. Lower class social strata hence, tend to adopt the tastes consistent with their class position in which they are preoccupied with acquiring items of necessity like food and shelter. Many scholars, however, argue that although SES is perhaps the major factor which dictates lifestyle selection and participation, it should not be taken as the sole determinant of lifestyle.

**Cockerham: A Theory of Health Lifestyles**

By drawing upon the works of Weber and Bourdieu, Cockerham (2007) formulated an initial theory of health lifestyles which encompass broad ranges of variables. Cockerham identified four categories of socio-structural variables that have the potential to shape health life styles. The categories, including: 1) class circumstances, 2) age, gender, race/ethnicity, 3) collectivities, and 4) living conditions.

The first category is class circumstances, which is the likely the most powerful influence on lifestyle forms. The lifestyles of the upper and middle classes are the healthiest and those of the lower class the least healthy. Virtually every study confirms this. As for the second category, that of age, gender and race/ethnicity:

- Age affects health lifestyles because people tend to take better care of their health as they grow older. They do this by showing more careful food selection, more relaxation, and abstinence or reduced use of tobacco and alcohol. Yet, exercise tends to decline with age.

- Gender is highly significant in that women eat more healthy foods , smoke less , visit doctors more often for preventive care , wear seat belts more frequently when they drive and with the exception of exercise have more healthier lifestyles overall than men.

- Race and ethnicity are presumed to be important, but there is little research showing this is the case. Most studies on race address differences in morbidly and mortality rather than healthy lifestyle practices. These studies often suggest that racial disparities in health are largely but jot exclusively determined by class position.

- The third category is collectives: Collectivities are group of actor whose members are linked together through particular relationships such as kinship, work, religion and politics. Their shared norms, values, ideas, and social perspectives reflect a particular collective viewpoint capable of influencing the health lifestyle of their members. For example, religious attitudes

which individuals develop due to their membership in collectivity have numerous positive effects on health-related activities (lifestyles) such as prohibition on smoking, drinking, and multiple sexual relationships, and the promotion of nutrition, hygiene, and exercise.

- The fourth category is living conditions: Living conditions are the other structural variables pertaining to differences in the quality of housing and access to basic utilities (like electricity, gas, heating, sewers, indoor plumbing,  and safe piped water), neighborhood facilities (like parks, recreation, and grocery stores) and personal safety.  So,  the conditions within which  a person lives  can have either  a positive  or  negative  impact on implementing  a healthy lifestyle.

Other than Weber's assumption, other findings suggested that healthy lifestyles need to go beyond an emphasis on SES and consider other variable that influence health practices. These structural variables including class circumstances provide the social context for socialization and experiences. Socialization (primary and secondary) and experience provides the capacity to make life  choices. This life choice is the self direction of one's behavior.  Life chances interact with choices to determine a person's health lifestyles because life chances either enable or constrain the choices made.

## Chapter Four: Social Sources and Patterning of Health and Illness

**An Introduction to Epidemiology**

The first concept we need to define is disease. To researchers working in health care, disease refers to a biological problem within an organism. Illness, on the other hand, refers to the social experience and consequences of having a disease. So, for example, an individual who becomes infected with the polio virus has the disease we call polio. When we refer, however, to subsequent changes in that individual's sense of self and social relationship, we should properly refer to these changes as consequences of the illness known as polio, not the disease.

The study of the distribution of disease within a population is known as epidemiology and the next focus more specifically on social epidemiology, or the distribution of disease within a population according to social factors (such as  social class or  use of tobacco) rather than biological factors (such as blood pressure or genetics). For example, whereas biologists might investigate whether heart disease is more common among those with high versus low cholesterol levels, social epidemiologists might investigate whether it is more common among smokers versus nonsmokers.

**When** investigating whether a disease is more common among one group than another, epidemiologists look at the rate rather than the number of cases in each group. Rate refers to the proportion of a specified population that experiences a given circumstance. Two particularly useful types of rates are incidence and prevalence rates. Incidence refers to the number of new occurrences of an event (disease, births, deaths and so on) within a specified population during a specified time period. Prevalence refers to the total number of cases within a specified population at a specified time—both those newly diagnosed and those diagnosed in previous years but still living with the condition under study.

In general, incidence better measures the spread of acute illnesses, such as chicken pox and influenza, which strike suddenly and disappear quickly. Incidence also better measures rapidly spreading diseases such as AIDS. For example, to see how AIDS spread during the first decade after it was identified, we would compare its incidence in 1981 to its incidence in 1991. Prevalence, on the other hand, better measures the frequency of chronic illnesses, which last for many years, such as muscular dystrophy, asthma and diabetes. Two final terms often used in epidemiology are morbidity and mortality. Morbidity refers to symptoms, illnesses and impairments; mortality refers to deaths. To assess the overall health of a population, epidemiologists typically calculate the rate of serious morbidity in a population (that is, the proportion suffering from serious illness), the rates of infant mortality and maternal mortality (that is, the proportion of infants and childbearing women who die during or soon after childbirth), and life expectancy (the average number of years individuals born in a certain year can expect to live).

**The Epidemiological Transition**

As industrialization and urbanization increased, mortality rates rose, especially among the urban poor. The main killer was tuberculosis, followed by influenza, pneumonia, typhus, and other infectious diseases. By the late nineteenth century, however, deaths from infectious diseases began to decline rapidly in the United States as in other industrialized countries. Although infectious diseases remained common, especially among the poor they no longer accounted for the majority of deaths. Partly as a result, infant and childhood mortality declined steeply. Between 1900 and 1930, life expectancy rose from 47 years to 60 years for whites and rose from 33 years to 48 years for African Americans (U.S Bureau of Census, 1975). As infant mortality declined, families no longer felt obligated to have many children to ensure that one or two would survive long enough to get work and bring income into the household. At the same time, the national economy continued to shift from agriculture to industry, reducing couples need to have children to work on the family frame. Similarly, employers increasingly offered pensions and other social benefits, so couples' need to have children to care for them in their old

age also declined. Taken together, these trends produced a sharp decline in family size. Consequently, families could devote more resources to each child, further increasing children's chances of survival. As infectious diseases declined in importance, chronic and degenerative diseases, which only can affect those who live long enough for symptoms to develop, gained importance. Cancer, heart disease, and stroke became major causes of mortality, while arthritis and diabetes emerged as major sources of morbidity. Increasingly, too conditions like heart disease, stroke, and hypertension shifted from being primarily diseases of the affluent to being disproportionately diseases of the poor.

The shift from a society characterized by infectious and parasitic diseases and low life expectancy to one characterized by degenerative and chronic diseases and high life expectancy is referred to as the epidemiological transition (Omran, 1971). This transition seems to occur around the world once a nation's mean per capita income reaches a threshold level (in 2002 dollars) of about $6,900(Wilkinson, 1996). Some countries have fully made the epidemiological transition while others have not. Contrary to conventional wisdom, medical interventions such as vaccinations, new drugs, and new surgical techniques played little role in the epidemiological transition, which began more than 200 years ago in western societies (Leavitt and Numbers, 1985; McKeown, 1979; McKinlay and McKinlay, 1977). In a series of dramatic graphs showing how mortality from several important disease declined over time, McKinlay and McKinlay (1977) have demonstrated that these declines by and large preceded the introduction of effective medical interventions. For example, the death rate for tuberculosis declined steadily from greater than 3.5 per 1,000 in 1860 to .34 per 1,000 in 1946. Yet, streptomycin, the first effective treatment for tuberculosis, was not introduced until 1947. Only polio and small pox declined substantially after the introduction of medical interventions. Of these two, only the decline in polio can be confidently attributed to medical intervention, as we cannot separate the possible impact of inoculation on the rate of small pox from the impact of the myriad other changes that occurred since inoculation was first widely adopted about 200 years ago. Summing up their data, Mckinlay and McKinlay (1977) estimate that medical measures account for at most 3.5 % of the total decline in mortality since 1900. More recent studies, using fairly generous assessments of the potential impact of modern medical care on life expectancy, have concluded that medical care can explain no more than one-sixth of the increase in life expectancy during the twentieth century (Bunker et al, 1994). These findings of course do not negate the importance of medical care for saving individual lives and certainly do not negate the enormous improvements in quality of life that medical techniques such as cataract surgery or pain relief have given the public. Nevertheless, these findings do underscore the limited effect

of medical care on broad changes in mortality rates. If medical interventions do not explain the decline in infectious diseases, what does? Research suggests that the decline in disease associated with the epidemiological transition in western societies resulted primarily from changes in the social environment (McKinlay and McKinalay, 1977). As nutrition and living conditions improved, so did individuals' ability to resist infection and to survive if they became infected. At the same time, although somewhat less importantly, public health improvements such as the development of clean water supplies and sanitary sewage systems increasingly protected individuals from exposure to disease causing microbes.

Given the enormous improvements in life expectancy during the twentieth century, it was natural for scientists to assume the life expectancy would continue to rise steadily along with incomes. However, a highly influential book published by Richard Wilkinson (1996), based on a diverse wealth of data from studies conducted around the world, argues that increases in average income above about $6,900(in 2002 dollars) brings only modest increases in life expectancy. Instead, further increases in life expectancy appear to occur not when absolute incomes increase but only when the relative income differential with in a country narrows. In other words, if the gap in income between rich and poor narrows, as it has in Costa Rica, for example, average life expectancy increases (especially among poorer citizens). Conversely, if the income gap widens, as happened following the collapse of the former Soviet Union, average life expectancy declines. As a result life expectancy is greatest within countries that have experienced the epidemiological transition and have the smallest income gap between rich and poor, like Sweden and Japan, rather than in countries like the United States, which despite its great wealth has the widest income gap among the industrialized nation(Bradsher, 1995).

After weighing all the available evidence, Wilkinson argues that the key to the better health found in societies with small income gaps is their social cohesion. These societies, he argues: have a strong community life. Instead of social life stopping outside the front door, public space remains a social space. The individualism and the values of the market are restrained by a social morality. People are more likely to be involved in social and voluntary activities outside the home… There are fewer sings of anti-social aggressiveness, and society appears more caring. In short, the social fabric is in better condition (Wilkinson, 1996:4).

This thesis explains not only why these societies have higher life expectancies but also why, as a rule, they are especially unlikely to experience high rates of mortality from conditions linked to social stress, such as accidents, violence, and alcohol related diseases. Importantly, Wilkinson notes that when societies reduce income inequality through increasing education, housing and employment

opportunities(as) Japan and Korea did following World War II), all members of the society benefit because lower-class persons become both more economically productive and less likely to engage in criminal or violent behaviors.

**Social Sources of Premature Deaths**

In a widely-cited article titled "A Case for Refocusing Upstream," sociologist John McKinlay (1994) offers the following oft-told tale as a metaphor for the modern doctor's dilemma:

Sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So jump into the river, put, my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling applying, breathing, and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore. Applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in (McKinlay, 1994:509-510).

This story illustrates the traditional emphasis within medicine on tertiary prevention: strategies designed to minimize physical deterioration and complications among those already ill. Tertiary prevention includes such tactics as providing kidney dialysis t o persons whose kidneys no longer function or insulin to those who have diabetes. Doctors much less commonly focus on secondary prevention: strategies designed to reduce the prevalence of disease through early detection and prompt intervention. Examples of secondary prevention include screening patients for cervical cancer or glaucoma so these diseases can be detected at still treatable stages. Those who focus on secondary prevention typically work in public health or in the primary practice fields (family practice, pediatrics, or internal medicine). Finally, only a small fraction of doctors, usually in public health or less commonly, primary practice, focus "upstream" on primary prevention: strategies designed to keep people from becoming ill or disabled, such as discouraging drunk driving, lobbying for stricter highway safety regulations, and promoting vaccination.

Even when doctors, researchers, (or for that matter, the general public) have focused on primary prevention, they typically have looked only far enough upstream to see how individual psychological or biological characteristics make some more susceptible than others to disease or unhealthy behaviors. For example, an increasing number of medical researchers now focus on the generic roots of disease, such as a possible gene for alcoholism. Within the social sciences, meanwhile, many researchers focus on

understanding how individuals chose whether to adopt behaviors believed to prevent illness, such as exercising regularly or refraining from smoking.

**The most** commonly used framework for understanding individual preventive health behavior is the health belief model, originated by Irwin Rosenstock (1966)  and extended, most importantly, by Marshall Becker (1974,1993). According to the model, four factors determine whether individual will adopt preventive health behaviors. **First,** individuals must believe they are susceptible to a particular health problem. **Second,** individuals must believe the problem they risk is a serious one. **Third,** individuals must believe adopting preventive measures will reduce their risks significantly. **Fourth,** individuals must not perceive any significant barriers to doing so.  For example, individuals are most likely to adopt a low-fat diet if they believe that they would otherwise face high risks of heart disease, that heart disease would substantially decrease their life expectancy, that a low fat diet would substantially reduce their risk of heart disease, and that adopting such a diet would not be too costly, inconvenient, or unpleasant.

In turn, according to the health belief model, these four factors are affected by demographic variables (such as the individual's gender and age), social psychological variables (such as personality characteristics and peer group pressures), structural factors (such as access to knowledge about the problem and contact with those who experience the problem), and external cues to action (such as media campaigns about the problem or doctors advices).

As this model suggests, although biological factors and psychological predispositions do affect the likelihood of adopting healthier behaviors, they do not occur in a vacuum. Rather, they occur in particular economic, cultural, and political settings that can make health behaviors or health itself either more or less possible. For example, adolescents' decisions regarding whether to drink alcohol are affected significantly by the attitudes of their friends, family, and culture in general. Similarly, the high rates of diabetes found among contemporary Native Americans in part reflect a genetic predisposition to the disease. They also, however, reflect the effects of the reservation system, with its sedentary lifestyle, ready access to fatty and sugary foods, limited access to fresh fruits and vegetables, and limited prospects for employment, which make purchasing healthier food difficult. In both cases, to blame unhealthy behavior patterns on individual choices seems over simplistic.

As these examples suggest, truly refocusing upstream requires us to look beyond individual behavior or characteristics to what McKinlay refers to as the manufacturers of illness: those groups that promote illness-causing behaviors and social conditions. These groups include alcohol distributors; auto

manufacturers that fight against vehicle safety standards, and politicians who vote to subsidize tobacco production.

An article by public health doctors J. Michael McGinnis and William H. Foege (1993) provides a useful starting point for refocusing upstream. The article synthesizes the available literature on the major underlying causes of premature deaths (that is, deaths caused neither by old age nor by genetic disease) to identify those causes of death that we could most readily reduce or eliminate though social or medical interventions. McGinnis and Foege identify nine causes that, they believe, together account for 50 % of all premature deaths. The causes are listed not by disease but by the factors that cause disease. The estimates of the prevalence (of the causes) reflect the lowest estimates given in the reviewed literature, so the actual prevalence could well be considerably higher.

**Tobacco**

Tobacco causes more premature deaths in the United States than any other legal or illegal drug. Whether smoked, chewed, or used as snuff, tobacco can cause an enormous range of disabling and fatal diseases, including heart disease, strokes, emphysema, and numerous cancers (World Health Organization, 1998c). About half of all smokers will die because of their tobacco use, with half of these dying in middle age and losing an average of 22 years from their normal life expectancy. Tobacco use also increases morbidity and mortality among those who must live and work around smokers, known as "passive smokers" (World Health Organization, 1998c). Similarly, both active and passive smoking can cause birth defects and infant mortality.

Unfortunately, quitting smoking is difficult, as use of nicotine (the active ingredient in tobacco) usually results in addiction. In other words, those who chew or smoke nicotine regularly, like those who use heroin regularly, experience a predictable combination of distressing physical symptoms, known as withdrawal, if they cease using the drug. Moreover, nicotine is more addictive than heroin: most individuals do not experience withdrawal from nicotine after using it only a few times (Weil and Rosen, 1998). Given nicotine's addictiveness, it is easy to understand why individuals continue smoking once they have started. But why do individuals begin smoking in the first place, especially when many initially find tobacco vile tasting and even nauseating? To answer this question, we need to look at the role of tobacco in American culture and at how tobacco manufactures have created that role.

Although used for centuries, tobacco only recently became a truly popular drug (Ravenholt, 1993). Its first spurt in popularity came at the beginning of the twentieth century, when manufactured cigarettes and "safety matches" first made smoking easy and portable. Its popularity grew steadily until the 1960s,

as a result of manufactures' success in getting cigarettes included in solders' rations; continuous advertising campaigns that associated smoking with social status and sexual pleasure; and federal subsidies for tobacco growers and cigarette manufacturers.

In 1964, however, use of tobacco plummeted, especially among the middle and upper classes, following publication of a report by the U.S. Surgeon General that declared cigarette smoking a cause of lung cancer. To replace smokers who quit or died, manufacturers have labored to gain new smokers, designing advertising campaigns to convince the public to associate tobacco with positive attributes and achievements rather than with death and disability. For the last thirty years, the tobacco industry has especially targeted young's, women, and minorities (White, 1988). As summarized in an article published in the American Journal of Public Health, research has found that

Tobacco marketing does reach youth. Young people are able to name and recognize cigarette ads and can also match cigarette brand name with cigarette slogans. More than half of current adolescent smokers and approximately one quarter of nonsmoking teens own cigarette promotional items and participate in these campaigns. Moreover, there is a growing recognition that such advertising and promotion influence teen smoking. Longitudinal studies of advertising patterns and young people's tobacco use demonstrate a positive association between advertising and teenage smoking. In a addition, the vast majority of adolescent smokers prefer the most heavily advertised brands and report that they would smoke the brand whose advertisements they liked most (Schooler et al,.1996).

Manufacturers also have targeted their marketing to women by playing on women's desire for equality, excitement, personal fulfillment, and weight loss (a cultural imperative for women in contemporary American culture and a major reason women smoke). This was exemplified by Virginia Slims—the name was not accidental – and its slogan, "You've come a long way, baby." To target minorities, manufacturers advertise heavily in magazines such as Ebony and Jet. They also have gained influence and visibility in minority communities by providing financial sponsorship for charitable organizations and civic and cultural events (While, 1988). In addition, until banned in 1996, manufacturers relied heavily on billboards placed low and close to the street in African-American and Hispanic (but not white) neighborhoods; these billboards were particularly good at attracting children's attention.

During the last few years, however, successful legal attacks on tobacco manufacturers have begun to erode their ability to attract new customers. Following a series of hearings that demonstrated tobacco manufacturers had known for decades that nicotine was addictive and had intentionally used manufacturing techniques to make cigarette smoking more addictive, the federal Food and Drug

Administration in 1996 adopted a series of regulations on the sale and advertisement of tobacco, mostly aimed at deterring youths from smoking (Hilts, 1993). Almost simultaneously all fifty states (some singly, some jointly) used the five largest tobacco manufacturers to recover the money states spend on medial care for citizens who have tobacco-related diseases. Under the terms of a joint settlement reached in late 1998, the tobacco companies will pay the states $206 billion over the next 25 years. Among the many other terms of that settlement, tobacco companies may no longer use cartoon characters in advertisements and must restrict their sponsorship of sports and entertainment events.

In response to these threats, tobacco manufactures have donated enormous sums - $ 8.4 million during 1999 - 2000 at the federal level - to political candidates to encourage them to support the manufacturers' interests (Center for Responsive Politics, www.opensecrets.org, accessed July 2002). For example, tobacco manufactures (and merchants) have pressed for passage of laws that criminalize the possession or use of tobacco by minors, while working against laws that criminalize the sale of tobacco to minors (Mosher, 1995). In this way, they hope to define tobacco use as individual choice and place the blame on consumers rather than on the tobacco industry.

**Alcohol**

Like tobacco, alcohol kills far more people than all illegal drugs combined. Heavy alcohol use can cause irreversible brain damage, hepatitis, heart disease, cirrhosis of the liver, and cancers of the digestive system while reducing the body's ability to fight infections such as tuberculoses and pneumonia. In addition, by diminishing individuals' ability to make rational choices, alcohol use contributes to deaths from drownings, fire, violence, and accidents and increases the odds of engaging in unsafe sexual behavior. Finally, withdrawal from alcohol is more dangerous than withdrawal from any other legal or illegal drug and can cause brain damage, heart failure, or stroke. Yet despite the dangers of alcohol, by law the U.S. Office of National Drug Control Policy cannot use any of its funds - $195 million during 1999 - to fight problem drinking; recent efforts to change this, supported by the American Medical Association and the American Public Health Association, have met fierce resistance from alcohol manufactures and distributors (Wren, 1999).

To ensure that the government continues to treat alcohol as a beverage rather than a drug, alcohol manufacturers contribute heavily to political campaigns, giving $12.9 million to federal candidates during the 1999-2000 election cycle alone (Center for Responsive Politics, http:// www.opensecrets.org). Manufacturers also have worked to define the individual drinker rather than alcohol itself as the problem by promoting the idea that alcoholism is a disease that only affects

susceptible individuals, funding research on biological roots of alcoholism, and like tobacco manufactures, supporting laws that criminalize underage drinking while fighting laws that would criminalize the sale of alcohol to minors (Morgan, 1998; Mosher 1995).

At the same time, alcohol manufacturers have worked diligently to sell alcohol to the public not as a drug but as a lifestyle, spending about $2billion per year on advertising. Much of this marketing either directly or indirectly targets youths, despite voluntary industry codes that forbid manufacturers from marketing alcohol to audiences in which a majority are under age 21. During 1997-98, only four of eight manufacturers studied by the Federal Trade Commission (1999) met even this lenient standard, and manufacturers paid to have their products appear on eight of the fifteen television shows most popular with teenagers. Advertisements typically associate alcohol with adulthood, sexual adventure, status, freedom, excitement, and pleasure. Meanwhile, alcohol also sells because it offers an effective, if self-destructive, way to dull the emotional pains of daily life and the physical pains of hunger, cold or abuse.

## Diet and Exercise

The second most common cause of premature deaths, according to McGinnis and Foege (1993), is a high-fat diet and sedentary lifestyle, which may increase the odds of developing cardiovascular disease, certain cancers (of the colon, breast, and prostate), and diabetes. Nutritionists agree that Americans would be fitter, feel healthier, and perhaps live longer if they increased their activity levels; reduced consumption of fats, sugars, salt, and meat; and increased consumption of fruits, vegetables, and whole grains. Such changes would most benefit poor Americans, who are more likely than others to eat unbalanced diets that emphasize sugars and fats because those foods provide energy and satisfy hunger most cheaply (James et al., 1997).

Unfortunately, humans have a natural craving for sweet and fatty foods, and physical exercise is no longer built into most Americans' work life or transportation patterns.  In addition, the tendency toward eating a sweet, fatty diet has been reinforced by food manufacturers. Because manufacturers earn far less money from selling healthier foods (like fruits, vegetables and grains) than selling highly refined products loaded with fat, sugar, and salt (like candy, soft drinks, and convenience foods), they spend more than 30 times as much to advertise the latter foods (Nestle, 2002: 22). The advertising has grown increasingly more insidious, wending into every corner of our society – especially where children can be found (for instance, by placing products in movies and sponsoring school sports teams).

Through their lobbying power in Congress, manufacturers also have significantly affected – and distorted - U.S. government food policy (Nestle, 2002). Because of industry pressure, the U.S.

Department of Agriculture (USDA) provides subsidies and price supports for dairy and meat producers, including purchasing high-fat products for free distribution to school lunch programs for poor children. In addition, beginning in 1956, the USDA heavily promoted, in schools and elsewhere, the concept of the "Basic Four" food groups: milk and milk products; meat, fish, and poultry (a group that included eggs, dried beans, and nuts); fruits and vegetables; and grains. These four food groups reflected the USDA's federally mandated goals of promoting the nation's dairy and meat industries and advising the public about diet. (Promoting public health, on the other hand, fell under the aegis of the Department of Health).

In the 1950s, promoting meat and dairy products and advising about diet did not seem contradictory goals, for the main nutritional problem in those years was how to improve the health of low-income groups whose diets offered insufficient nutrition. By the 1970s, however, health care researchers had stopped worrying that Americans were not eating enough and had begun worrying that Americans were eating too much, especially fat and cholesterol. From this point on, the USDA would find it increasingly difficult to protect the food industries unless it ignored nutrition research on the impact of diet on health. The results of this dilemma can be seen in the USDA's current dietary guidelines. Although the guidelines now recommend eating a low fat diet and emphasize fruits, vegetables, and grains, they still recommend two to three daily servings of dairy products and an additional two to three servings of meat or other proteins, with a serving defined as 5 to 7 ounces of cooked meat. Yet both dairy products and meat often have high fat and cholesterol levels. Moreover, the majority of nonwhite Americans lack the enzyme needed to digest dairy products and suffer intestinal distress when they eat them.

**Toxic Agents**

McGinnis and Foege (1993) trace 3 % of premature deaths to toxic agents. These agents can be divided into occupational hazards and environmental pollutants. In "light" industries like electronics, workers are often exposed to a wide variety of potentially toxic solvents, such as trichloroethylene (TCE), while in traditional industries such as mining and construction, and welders often face substantially increased risks of lung cancer caused by toxic levels of chromium and nickel. Similarly, agricultural workers are regularly exposed to dangerous pesticides.

Unlike occupational hazards, environmental pollution poses the greatest dangers to children, because of their still-growing bodies and immune systems, the time they spend playing outdoors, and their tendency to play on the ground and put things in their mouths. Many forms of environmental pollution threaten children U.S. Environmental Protection Agency, 1996). For example, about 9000,000 U.S. children

under age 6 have elevated levers of lead in their blood from eating old house paint, which can cause retardation, learning disabilities, hearing deficiencies, hyperactivity, and other problems. Twenty-four thousand children each year are poisoned by eating pesticides, and many more are exposed to pesticides on food. Similarly, 33 % of U.S. children now live in areas that do not meet national air quality standards, which partly explains why 4.8 million children have asthma. Finally, 10 million children under the age of 12 live within four miles of a toxic waste dump, increasing their risks of cancer and generic defects (U.S. Environmental Protection Agency, 1996).

In the long run, the greatest environmental health threat may be global warming. During the last quarter century, carbon dioxide and synthetic gases, especially chlorofluorocarbons (CFCs) such as Freon, have mushroomed. According to the Intergovernmental Panel on Climate Change, a joint venture of the World Meteorological Organization and the United Nations Environmental programmed (Houghton et al., 1996), these chemical by-products of industrial manufacturing have damaged the ozone level surrounding the planet and caused temperatures to rise around the globe. Debate continues about the consequences of global warming, but many scientists suspect the global warming and the resulting damage to the ozone level will foster genetic mutations, cancers (especially skin cancer), and smog-related health problems such as bronchitis, asthma, and emphysema.

**Sexual Behavior**

McGinnis and Foege (1993) attribute 1 % of premature deaths to sexual behavior, primarily via hepatitis B, HIV, and cervical cancer. (Although the precise mechanisms causing cervical cancer is unknown, it occurs most often among those who have multiple sexual partners and do not use condoms, diaphragms, or spermicidal.) McGinnis and Foege also include in this category infant mortality following unplanned and unwanted pregnancies, a situation occurring most commonly among teenagers and poor women.

No, "manufacturer of illness" benefits from convincing people to engage in sexual activity without protecting themselves against disease or pregnancy. However, social conditions can encourage such behavior. First, those forced by economic necessity to turn to prostitution to support themselves, whether male or female, often find that they cannot suggest safer sex to clients without either losing business or risking violence. Similarly those whose intimate relationships are not based on mutual respect and equality sometimes find that suggesting safer sex to their romantic partners results in violence or abandonment (Wingood and DiClemente, 1997). Finally those who have learned to have little hope for the future - a sentiment particularly common among youths in communities wracked by

racism and poverty - sometimes feel they have little to lose by engaging in unsafe sexual activity (Plotnick, 1992). Other sexually active individuals, however, do fear both sexually transmitted diseases and pregnancy. For these individuals, sexual activity does not need to lead to disease or pregnancy if they have knowledge about safer sexual practices and access to birth control and abortion. Safer sexual practices have become more common in the last decade, but access to birth control and abortion has declined. Cuts in public funding for contraceptive services have limited options for precisely those groups' teenagers and low income women—most at risk for unplanned pregnancies and infant mortality (Henshaw, 1995). Similarly, the federal government will not pay for abortions for women on Medicaid (the government-funded health insurance program for poor persons) unless the woman's life is endangered. 20 - 37 % of women who would have had an abortion if Medicaid paid for it now carry to term (Henshaw, 1995). Meanwhile, cutbacks in government funding for abortions, coupled with harassment and violence against abortion providers, have reduced the number and geographic distribution of abortion providers. As of 2000, 32 % of women ages 15 to 44 lived in counties without any abortion provider (Henshaw and Finer, 2003). Other restrictions, such as requiring waiting periods or parental consent, also have limited access to abortion, especially for poor and young women whose babies are most at risk for death or disability if they carry to term.

# Chapter Five: Health Behavior and Health Lifestyles

**Health and Illness Behavior, and Healthy Lifestyles**

Health lifestyle is an important area of investigation in medical sociology, because health oriented behavior does not pertain just those activities concerned with recovering from disease or injury. It also involves the kinds of things that healthy people do to stay healthy. Consequently, medical sociologists divided health oriented behavior into two general categories i.e. health behavior (the behavior or the lifestyle of healthy people) and illness behavior (the behavior of people who feel sick  and are in need of medical treatment).  Illness behavior where by a person who feels ill is engaged in some activities for the purpose of defining that illness and seeking relief from it. Health behavior, in contrast, is defined as the activity undertaken by individuals for the purpose of maintaining and/or enhancing their health, preventing health problems, or achieving a positive body image (Cockerham, 2007: 99).  This definition does not limit participation to healthy people who try to stay healthy. Instead, it includes people in good health as well as the physically handicapped as well as persons with chronic illness like diabetes and heart disease that seek to control or contain their affliction through diet, exercise, and other forms of

health behavior. It also includes persons whose primary motivation in regard to health behavior is their desire to look and feel good (some people focus on enhancing their bodily appearance and physical condition to appear attractive and successful (Kotarba and Bentley, 1988).

For most other people, however, their health behavior is primarily intended to prolong their lives and maintain their health (Goldstein, 1992). Yet, regardless of the underlying motivation, it is clear that health-promoting behavior and lifestyles are spreading in many societies. The focus in medical sociology is not on the health behavior of individual, but on the transformation of this behavior into its collective form-health lifestyles. Health lifestyles are collective patterns of health related behavior based on choices from options available to people in line with their life chances. A person's life chances are largely determined by his or her class position that either enable or constrain health lifestyles choices. The behaviors that are generated from these choices can have either positive or negative consequences on body and mind, but nonetheless form an overall pattern of health practices that contribute a lifestyle. Health lifestyles include contact with medical professionals for checkups and preventive care, but the majority of activities take place outside the health care delivery system. These activities typically consist of choices and practices, influenced by the individual's probabilities for realizing them, that range from brushing one's teeth and using automobile seat belts to relaxing.

For most people, healthy lifestyles involve decisions about food, exercise, relaxation, personal hygiene, risk of accidents, coping with stress, smoking, alcohol and drug use, as well as having physical checkups.  According to the WHO, the first 60 years of the twentieth century was the "medical era," in which the dominant approach to health was mass vaccination and the extensive use of antibiotics to combat infection. At present, however, WHO suggests that advanced societies are entering into a" postmedical era" in which physical well-being is largely undermined by social and environmental factors. These factors include certain types of individual behavior (smoking, overeating), failure of social organization (loneness), economic factor (poverty), and the physical environment (pollution) that are not amenable to direct improvement by medicine. The role of health lifestyles as a means to improve the health of people in a postmedical situation is gaining in significance as the twenty first century begins.  Why?

Roben Craford (1984) helps us to understand why this is the case as:

First, there has been a growing recognition among the general public that the major disease patterns have changed from acute or infectious illness to chronic diseases-like heart disease, cancer, and diabetes-that medicine cannot cure. Second, numerous health problems, such as AIDS and cigarette-

induced lung cancer, are caused by particular styles of living. Third, there has been a virtual campaign by the mass media and heath care providers, emphasizing lifestyle change and individual responsibility for health. The result has been a growing awareness that medicine is no longer the automatic answer to dealing with all threats to one's health. Therefore, strategies on the part of individuals to adopt a healthier lifestyle have gained in popularity. As Crawford Explains when threats to health persist in the environment and medicine cannot provide a cure, self-control over the range of personal behaviors that affect health is the only remaining option. This means the person will be confronted with decision to acquire or maintain a healthy lifestyle, or disregard the situation and perhaps be at greater risk for poor health.

*Illness behavior,* in comparison to healthy behavior, is the activity undertaken by a person who feels ill for the purpose of defining that illness and seeking relief from it. As David Mechanic explains, illness behaviors refer the varying ways individuals respond to bodily indicators: How they monitor internal states, define and interpret symptoms, make attributions, take remedial actions, and utilize various resources of informal and formal care.

Some people recognize particular physical symptoms such as pain, a high fever, or nausea and seek out a physician for treatment. Others with similar symptoms may attempt self-medication or dismiss the symptoms as not needing attention. Social and psychological factors that shape the individual's response to the often subtle bodily changes that are experienced in daily living. Thus, subjective interpretations of feeling states become highly social and psychological. Why we need to study illness behavior? To review the social factors influencing the decisions of the ill to use professional medical services.

**Self-care**

It is the most common response to symptoms of illness by people throughout the world. It includes taking preventive measures like: Consuming vitamin supplements; Self-treatment of symptoms (such as taking home remedial or over-the counter drugs); chronic conditions (for instance, use of insulin by a diabetic).

Self-care may involve consultation with health care providers and use of their services. It is essentially consists of a layperson's preventing, detecting, and treating his or her own health problems. What makes self-care distinctive is that it is a form of care that is self-initiated and self-managed (Segall and Goldstein 1989). In modern societies, a number of factors have promoted interest in self-care on the part of laypersons. What do you think about the factors?

According to Alexander Segall and Jay Goldstein (1989), these factors include: 1) The shift in disease patterns from acute to chronic illnesses and the accompanying need to displace medical intervention from an emphasis on cure to care; 2) Growing public dissatisfaction with medical care that is depersonalized; 3) Recognition of the limits of modern medicine; 4) The increasing visibility of alternative healing practices; 5) Heightened consciousness of the effects of lifestyles on health; 6) A desire to express personal responsibility in health-related matters; and 7) Access to the internet, with its abundance of medical information.

Thus, it would appear that self-care is becoming increasingly important and commonplace. Yet, self-care is not an action that is completely independent of the medical profession. People engaged in self-care in a matter consistent with medical norms, values, and information. Often medical advice guides the action taken. When laypersons lack knowledge, competence, or experience to proceed, or are simply more comfortable in allowing professionals to handle matters, they turn to doctors.

# Chapter Six: Illness Behavior and Sick Role Behavior

## Explaining Illness

The moral status of illness is reinforced by the tendency to explain illness by blaming it on those who are ill (Brandt and Rozin, 1997; Weitz, 1991). Because people consider illness undesirable and because it can strike anyone at any time, people often react to illness with fear and confusion. As a result, people typically need to explain why illness occurs and, especially, why illness strikes some persons and not others. Having an explanation helps to relieve anxiety by making the world seem less capricious and frightening.

Most often—and as the example of HIV disease has vividly demonstrated—these explanations relieve anxiety by defining illness as a deserved punishment, blaming the individual for his or her illness. Whether accurate or inaccurate, these explanations provide psychological reassurance by reinforcing people's belief in a "just world," in which punishment fall only on the guilty (Burger, 1981; Lerner and Miller, 1978; Meyerowitz, Williams, and Gessner, 1987). Even those who are themselves ill may prefer to blame themselves rather than to believe that random, impersonal events control their fates.

## Pre-scientific Explanations

Throughout history and across cultures, people typically have explained illness by blaming those who are ill. According to George Foster (1976), all traditional theories of illness causation around the world divide into only two somewhat overlapping, categories: "personality" and "naturalistic". Personalistic

theories, the more common type (Murdock, 1980), hold that illness occurs when a god, witch, spirit, or other supernatural power lashes out at an individual, either deservedly or maliciously. Naturalistic theories assert that illness occurs when heat, cold, wind, damp, or other natural forces upset the body's equilibrium. Both personality and naturalistic the oriels blame ill persons for causing their illness, whether by displeasing supernatural beings or by exposing themselves to harmful natural elements. And both define ill personas as less morally worthy than others, whether as sinners or as fools. Personalistic theories have played an especially important role in the Western world, which in the past often equated illness with divine punishment for sin (Murdock, 1980:42-52). The history of leprosy provides an obvious example. Both the Jewish and Christian Bibles consistently describe leprosy as punishment for an individual's sin. Biblical explanation for leprosy, coupled perhaps with some awareness that leprosy was contiguous, led early Western societies to isolate affected individuals, an approach that continued essentially unchanged for centuries. Throughout the Middle Ages and unite the Reformation, Christian society required anyone diagnosed with leprosy to participate in a special mass for the dead known as the "lepers' Mass." Following the mass, a priest would shovel dirt on the individual's feet to symbolize his or her civil and religious death, from then on, the individual was legally prohibited from entering public gathering places, wasting in springs or streams, drinking from another's cup, wearing anything other than the special "leper's dress," touching anything before buying it, talking to anyone without first moving downwind, and so on (Richards, 1977:123-124). This social banishment continued even after death: like those who committed suicide or other mortal sins, persons with leprosy could not be buried in church graveyards.

**The Rise of Scientific Explanations**

By the early nineteenth century, prescientific ideas about illness had begun to erode, as the idea grew, especially among the elite, that scientific principles controlled the natural order. According to the new scientific thinking, illness occurred when biological forces combined with personal susceptibility. Doctors (still lacking a concept of germs) argued that illness occurred when persons whose constitutions were naturally weak or had been weakened by unhealthy behaviors came in contact with dangerous "miasma or air "corrupted" by foul odors and fumes. According to this theory, therefore individuals became ill because of unhealthy rather than immoral behavior.

As the history of cholera shows, however, these new ideas still allowed the healthy to blame the ill for their illnesses. Cholera first appeared in the Western world in about 1830, killing its victims suddenly

and horrifyingly through overwhelming dehydration brought on by uncontrollable diarrhea and vomiting. Cholera is caused by waterborne bacteria, generally transmitted when human wastes contaminate food or drinking water. Because of the link to sanitation, cholera most often strikes poor persons who lack clean water and are weakened by insufficient food, clothing, or shelter.

To explain why cholera has struck and why it struck the poor especially hard, early nineteenth century doctors asserted that cholera could only attack individuals who had weakened their bodies through improper living (Rise, 1988, Rosenberg, 1987). According to this theory, the poor caused their own illnesses, first by lacking the imitative required to escape poverty and then by choosing to eat an unhealthy diet, live in dirty condition, or drink too much alcohol, thus, for example, the New York City Medical Council could conclude in 1832 that "the disease in the city is confined to the imprudent, the intemperate, and to those who injure themselves by taking improper medicines" (Risse, 1988:45). Conversely, doctors assumed that wealthy persons would become ill only through gluttony, greed, or "innocently" inhaling some particularly noxious air. Using this theory, doctors, foreshadowing what would happen with HIV disease, divided patients into the "guilty" (the overwhelming majority), the "innocent," and the "suspect," and  hospitals provided or refused care accordingly (Risse, 1988;Rosenberg, 1987). This theory of illness allowed the upper classes to adopt the new, scientific explanations for illness while retaining older, moralistic assumptions about ill people and avoiding any sense of responsibility for adding the poor or the ill. In sum, instead of believing that immorality directly caused illness, people now believed that immorality left one susceptible to illness.


**Modern Explanation for Illness**

Despite the tremendous growth in medical knowledge about illness during the last century, popular explanations for illness have remained remarkably stable. Theories connecting illness to sin continue to appear, as do theories that conceptualize illness as a direct consequence of poorly chosen and hence irresponsible (although not necessarily sinful) behavior (Blaxter, 1983; Brandt and Rosn, 1997; Helman, 1986; Pill and Scott, 1983; Zola, 1972). For example, although most Americans know that viruses cause influenza and the common cold, most continue to hold essentially naturalistic theories regarding these illnesses—warning their children to eat warm foods, wear hats and gloves, and cover up against the rain to avoid infection. Similarly, the mass media, public health authorities, and the general public now often blame illness on individual life–styles (Brandt and Rozin, 1997; Tesh, 1988). Magazines regularly print

articles such as "Beat Your Risk Factors" (Libov, 1999) and "Ten easy ways to boost your immunity" (Shape, March 2000), exhorting individuals to protect or restore their health through diet, exercise, stress reduction, and the like. Simultaneously, the U.S. government-even while continuing to subsidize the tobacco and beef industries—spends millions on education campaigns to encourage the public to stop smoking and to a eat a healthier diet.

Another popular ideology ties illness not to individual actions but to individual personalities (Sontag, 1978).  Similarly, the media continue to warn that affective and competitive Type A personalities can cause heart problems (Siegman and Dembroski, 1989), despite a string of studies refuting this concept (Aronowitz, 1998).

In its most extreme form this sort of theorizing has led some to claim that illness occurs not because individuals ignore their bodies or have illness producing personalities but because they choose to become ill. The most influential statement of this theory appears in the bestselling book Love, Medicine and Miracles by surgeon Bernie Siegel (1990). Siegel postulates that people become ill because they "need" their illness—to escape a stressful work situation, receive sympathy from their spouses, punish themselves for misdeeds, and so on - and because they do not love themselves enough to take care of their emotional needs. Consequently, Siegel advises ill persons that they will find lasting cures only when they truly desire a healthy, long life.

Theories such as Siegel's draw on research suggesting that stress, personality, and life-style can increase personal susceptibility to illness. Such factors may indeed affect the distribution of illness in society. Yet by focusing on these factors as the primary sources of illness, these theories encourage the healthy to devalue and reject those who are ill and promote depression and lowered self-esteem among those who blame themselves or their illnesses. In addition, by emphasizing how individuals cause their own illnesses, these theories encourage policymakers to ignore how social and environmental factors can foster illness (Crawford, 1979; Tesh, 1988; Waitzkin, 1981; Zola, 1972). For example, magazines that emphasize how individuals make themselves ill rarely discuss how factors largely beyond individual control (such as poverty, malnutrition, pollution, or unsafe conditions in our houses, cars, or workplaces) can produce ill health. Nor do these magazines discuss how social factors (including the advertisements for alcohol and cigarettes in some of these same magazines) can pressure individuals to adopt unhealthy life-styles—how unemployed teenagers with poor job prospects sometimes smoke cigarettes to demonstrate their adulthood, how young mothers who lack assistance with child care probably also lack time for the recommended three sessions per week of aerobic exercise, or how workers sometimes suffer

injuries because of unsafe equipment rather than because of personal carelessness. As Barbara Katz Rothman (1989:21) notes,

Think of the anti-smoking, anti-drinking "behave you" campaigns aimed increasing at pregnant women. What are the causes [as identified in these campaigns] of prematurity, fetal defects damaged newborns—flawed products? Bad mothers, of course—inept workers. One New York City subway ad series shows two newborn footprints, one from a full-term and one from a premature infant. The ads read, "Guess which baby's mother smoked while pregnant?" Another asks, "Guess which baby's mother drank while pregnant?" And yet another: "Guess which baby's mother didn't get prenatal care?" I look in vain for the ad that says "Guess which mother tried to get by on welfare?" ; "Guess which baby's mother had to live on the treats?"; or "Guess which baby's mother was beaten by her husband?" (1989: 21)

In sum, whether or not they are accurate, theories of illness that focus on individual responsibility reinforce existing social arrangements and help us rationalize our tendency to reject mistreat, or simply ignore those who suffer illness.

**The Medical and the Sociological Models of Illness**

**The Medical Model of Illness**

According to the sociological model, then, illness is a moral status referring to conditions or behaviors deemed undesirable by powerful social groups. But what do doctors mean when they declare something an illness? To answer this question, we need to look at the medical model of illness. This model is not accepted in its entirety by all doctors – those in public health, pediatrics, and family practice are especially likely to question it—and is not rejected by all sociologists, but it is the dominant conception of illness in the medical world.

The medical model consist of five doctrines: that illness is (1) deviation from normal, (2) specific and universal, (3) caused by unique biological forces, (4) analogous to the breakdown of a machine, and (5) defined and treated medically through a neutral, scientific process.

First, the medical model defines illness narrowly as a deviation from normal biological functioning (Mishler, 1981). In contrast, other cultures define illness more broadly as an absence of balance or well-being or as undue pain, discomfort, or disability. For example, traditional Navajos define illness as a lack of harmony in and with the universe, and the World Health Organization defines illness as anything less than a complete state of physical, social and mental well-being. Defining illness as deviation from

normality assumes that we know and can easily recognize what is normal. Yet the nature of normality varies from person to person and group to group. A height of 4 feet 6 inches would be normal for a Pygmy man but not for a man born in the United States. Similarly, drinking three glasses of wine a day would be normal for an Italian woman but would raise eyebrows in many American social circles, in defining normality, therefore, we need to look not only at individual bodies but also at the broader social context. Moreover, even within a given group, "normality" is a range and not an absolute, the median hight of men in the United States, for example, is about 5 feet 9 inches, but most people would consider some one several inches taller or shorter than that still normal. Similarly, individual Italians routinely and without social difficulties drink more or less alcohol than the average Italian. In addition, defining illness as deviation from normal encourages doctors to define those with measurable risks of illness as if they already have an illness. For example, doctors now typically label persons who have higher than average blood—pressure and, hence, based on statistically averages, and elevated risk of heart disease or strokes—as having the disease of hypertension.

Second, the medical model assumes illness is both specific and universal, (Dubod, 1961; Mishler, 1981). The model assumes that each illness has specific features recognizable through clear, objective measures that differentiate it both from other illnesses and from health. This assumption, however, is problematic, for deciding which biological or psychological conditions constitute illnesses is a subjective and political process. In addition, diagnosing whether an individual has an illness is also highly subjective. Two patients with the same symptoms may receive different diagnoses depending on their doctors, countries of residence, ages, genders, ethnicities, and so on. At the same time, doctors often differentiate illnesses from health according to arbitrary statistical cutoffs rather than according to any inherence or absolute differences, for example, doctors typically recommend dietary changes for anyone with a cholesterol level higher than average for the U.S. population and recommend both drug therapy and dietary changes for anyone with a level in the top 20 % of the population. These treatment regimens, which in essence define half of Americans as ill, are based on statistical data regarding cholesterol levels, rather than on any absolute differences between those defined as healthy and those defined as ill. The assumption that illness is universal - that each illness manifests itself in the same way across time, people and cultures is also problematic. In practice, the model assumes that illnesses manifest themselves in other cultures in the same way as in Western culture and, by extensions that doctors can readily transfer their knowledge of illness developed in the West to the treatment and prevention of illness elsewhere. Yet other cultures recognize illnesses for which Western medical culture has no

counter part. For example, Latin American culture assigns the diagnosis of "susto" to individuals who experience restless sleep, listlessness, depression, and loss of appetite and attributes this illness to frights that cause the soul to wander from the body. Similarly, illnesses recognized by Western medical culture can have a different appearance and natural progression elsewhere. For example, the measles virus typically causes a mild childhood illness in industrialized nations but causes a deactivating disease in developing nations, whereas the microorganism that in the developing nations causes yaws, a mild childhood disease, causes syphilis in the Unites States (Brothwell, 1993:1097). By the same token, illnesses can manifest themselves differently in different age groups: the polio germ, for example typically causes paralysis in adults but only flu –like symptoms in very young children.

Third, the medical model assumes each illness has a unique etiology or cause (Mishler, 1981). Modern medicine assumes, for example, that tuberculosis, polio, HIV disease, and so on, are each caused by a unique microorganism. Similarly, doctors continue to search for limited and unique cause of heart disease and cancer, such as high cholesterol diets and exposure to asbestos. Yet even though illness causing microorganisms exist everywhere and environmental health dangers are common, relatively few people become ill because of these conditions. By the same token, although cholesterol levels and heart disease are strongly correlated among middle aged men, many men eat low-cholesterol diets but fall ill anyway. The doctrine of unique etiology discourages medical researchers from asking why individuals respond in such different ways to the same potentially illness-causing factors and encourages researchers to search for magic bullets – a term first used by Paul Ehrlich, the discoverer of the first effective treatment for syphilis, to refer to drugs that almost miraculously prevent or cure illness by attacking one specific etiological factors.

Fourth, the medical model conceptualizes the body as a machine or factory and illness as a breakdown of those mechanisms (Martin, 1987; Mishler, 1981; Osherson and Amara Singham, 1981 Waitzkin, 1993). For example, medical textbooks routinely describe the biochemistry of cells as a "production line" for converting energy into different products and describe the female reproductive system as a hierarchically organized factory of singling machines, which "breaks down" at menopauses (Martin, 1987). Similarly, medical writers typically describe HIV disease as a mechanical failure of the body's immunes systems (Sontag, 1978).

This mechanistic model encourages doctors to treat individuals in a reductionistic rather than holistic fashion. Reductionistic treatment refers to treatment in which doctors consider each bodily part separately from the whole, in the same way auto mechanics might replace an inefficient air filter without

worrying whether the problem with the air filter reflected or caused problems in the car's fuel system. Similarly, doctors might perform wrist surgery to correct problem experienced by typists without first investigating whether simple behavioral changes, such as getting furniture that fits the typists' better or using wrist rests to take the strain off their wrists while typing, might solve the problem. In contrast, holistic treatment assumes that all aspects of an individual's life and body are interconnected—that, for example, to treat an individual with cancer, health care workers must not only treat the tumor but also explore sources of illness elsewhere in the body and in the individual's psychological and social circumstance. Like the doctrine of unique etiology, the mechanistic model encourages doctors to seek the source of problems within the individual body rather than within the broader social environment. By extension, this doctrine encourages doctors to develop increasingly sophisticated technological fixes, such as organ transplants for persons with lung cancer, rather than to work toward social interventions, such as banning tobacco advertisements to prevent lung cancer in the first place (Waitzkin, 1993:174).

Finally, the medical model assumes that the definition, diagnosis, and treatment of illness are neutral, scientific matter unaffected by moral or subjective judgments or vested personal interests (Waitzkin, 1993). Yet, for example, rates of surgery for any given condition vary wildly across the United States—and usually are highest in areas where large numbers of surgeons compete for the same pool of patients (Center for the Evaluate Clinical Sciences, 1996). The medical model further assumes that, because medicine is an objective, scientific field requiring highly technical skills and knowledge, only doctors are qualified to define, diagnose, or treat illness. These assumptions reinforce the social power of medicine and ignore how social value affect our definitions of and responses to illnesses (Waitzkin, 1993).

**The Sociological Model of Illness**

What makes something an illness? The answer for this question is far from obvious. Most Americans are fairly confident that someone who has a cold or cancer is ill. But what about someone who has trouble learning, drinks to excess, or enjoys hitting others? What about a 60-years-old woman who no longer menstruates or whose bones have become more brittle with age? Or a 65-year-old man, who, like many his age, is balding or has an enlarged prostate gland and urinary problems?

As these examples suggest, defining something as an illness reflects more than simply the objective nature of the condition or behavior, rather, it reflects a subjective judgment regarding its meaning (Weitz, 1991). For example, defining menopause, as many American doctors now do, as a "hormonal deficiency disease" means defining it as abnormal and undesirable, rather than as the natural result of

aging. Yet many women experience menopause not as a sign of a declining body but as freedom from the, constrains of reproduction (Martin, 1987). Moreover, in some parts of the world, surviving to menopause signals not decline but rather maturity and wisdom and brings a higher social status. In the same manner, when we define cancer, polio, or diabetes as illness, we judge the bodily changes these conditions produce as abnormal and undesirable, rather than as normal variations in functioning, abilities, and life expectancies. (Conversely, when we define a condition as healthy, we judge it normal and desirable.)

The subjective and even political elements involved in defining illness are sometimes explicit. For example, in 1989, the American Society for Plastic and Reconstructive Surgery, the foremost professional organization fro plastic surgeons, petitioned the federal government to loosen its restrictions on the use of breast implant, on the grounds that implants are medically necessary to cure the "disease" of small breasts. In their words: "these deformities (i.e. small breasts) are really a disease which in most patients results in feelings of inadequacy, lack of self-confidence, distortion of body image and a total lack of well-being due to a lack of self-perceived femininity"(American Society of Plastic and Reconstructive Surgeons, 1989:4-5). Conversely, in Brazil, where large breasts are considered a sing of American heritage and, consequently, lower-class status, breast reduction is the most popular form of cosmetic surgery and is a popular sixteenth birthday gift (Gilman, 1999). These two opposite examples strongly suffers that defining breast size as a disease requiring medical intervention reflects cultural values and economic interests' at least as much as biological reality.

Illness, then, is a social construction, something that exists in the world not as an objective condition but because we have defined it as existing. This does not mean that the virus that causes measles does not exist or that it does not cause a fever and rash. It does mean, though, that when we talk about measles as an illness, we have organized our ideas about that virus, fever, and rash in only one of the many possible ways. In another place or time, people might conceptualize those same conditions as manifestations of witchcraft, as a healthy response to the presence of microbes, or under a different illness rubric. In sum, "illness," like "crime" or "sin," refers to biological, psychological, or social conditions subjectively defined as undesirable by those within a given culture that have the power to create such definitions.

If labeling a condition an illness reflects the perceived undesirability of that condition, then labeling someone ill suggests, if unintentionally, that there is something undesirable about that person. By definition, an ill person is one whose actions, ability, or appearance do not meet social norms, or expectations within a given culture regarding proper behavior or appearance. Such a person will

typically be considered less whole and less socially worthy than those deemed healthy. Illness, then like virginity or laziness, is a moral status - a social condition that we believe indicates the goodness or badness, worthiness or unworthiness, of a person.

From a sociological standpoint, illness is not only a moral status but (again, like crime or sin) a form of deviance (Parsons, 1951). To sociologists, labeling something deviant does not necessarily mean it is immoral. Rather, deviance refers to behaviors or conditions that socially powerful persons within a given culture perceive, whether accurately or inaccurately, as immoral or as violating social norms. We can tell whether behavior violates norms (and, therefore, whether it is deviant) by seeing if it results in negative social sanctions. This term refers to any punishment, from ridicule to execution. (Conversely, the term positive social sanction refers to rewards, ranging from token gifts to knighthood.) These social sanctions are enforced by social control agents including parents, police, teachers, peers, and doctors. In the next sections, I look at how societies explain illness and describe some of the negative social sanctions imposed against those who are ill.

**Illness as Deviance: the Sick Role**

Until now, we have looked at how medicine functions as an institution of social control by defining individuals either as sick or as biologically defective. Medicine also can work as an institution of social control by pressuring individuals to abandon sickness, a process first recognized by Talcott Parsons (1951). Parsons was one of the first and most influential sociologists to recognize that illness is deviance. From Parsons' perspective, when people are ill, they cannot perform the social tasks normally expected of them. Workers stay home, housewives tell their children to make their own meals, students ask to be excused from exams. Because of this, either consciously or unconsciously, people can use illness to evade their social responsibilities. To Parsons, therefore, illness threatened social stability. Parsons also recognized, however, that allowing some illness can increase social stability. Imagine a world in which no one could ever "call in sick". Over time, production levels would fall as individuals, denied needed recuperation time, succumbed to physical ailments. Morale, too, would fall while resentment would rise among those forced to perform their social duties day after day without relief. Illness, then, acts as a kind of pressure valve for society—something we recognize when we speak of taking time off work for "mental health days".

From Parsons' perspective, then, the important question was 'how did society control illnesses,' so that it would increase rather than decrease social stability? Parsons' emphasis on social stability reflected his belief in the broad social perspective known as functionalism. Underlying functionalism is an image of

society as a smoothly working, integrated whole, much like the biological concept of the human body as a homeostatic environment. In this model, social order is maintained because individuals learn to accept society's norms and because society's needs and individuals' needs match closely, making rebellion unnecessary. Within this model, deviance, including illness, is usually considered dysfunctional because it threatens to undermine social stability.

## Defining the Sick Role

Parsons' interest in how society manages to allow illness while minimizing its impact led him to develop the concept of the Sick role. The sick role refers to social expectations regarding how society should view sick people and how sick people should behave. The concept of Parsons' the sick role can be categorized into four basic categories (Cocherem, 2007: 148):

*a. The sick person is exempted from "normal" social roles.* The sick person is considered to have a legitimate reason for not fulfilling his or her normal social role. An individual's illness is used as grounds for his or her exemption from normal role performance and social responsibilities. This exemption, however, is relative to the nature and severity of the illness. The more severe the illness is the greater the exemption. Exemption requires legitimizing by the physician as the authority on what constitutes sickness. Legitimizing serves the social function of protecting society against malingering.

*b. The sick person is not responsible for his or her condition.* An individual's illness is usually thought to be beyond his or her own control. Here, sickness is considered beyond individual control, something for which the individual is not held responsible. A morbid condition of the body needs to be changed and some curative processes apart from personal will power or motivation is needed to get well. This is why; according to Parsons, we bring chicken soup to people who have colds rather than jailing them for stupidly exposing themselves to germs.

*c. The sick person should try to get well.* The first two aspects of the sick role are conditional on the third aspect which is recognition by the sick person that being sick is undesirable or undesirable and work to get well.. Exemption from normal responsibilities is temporary and conditional upon the desired to regain normal health. Hence the sick person has an obligation to get well. So, for example, we sympathize with people who obviously hate being ill and strive to get well and question the motives of those who seem to revel in the attention their illness brings.

*d. The sick person should seek technically competent help and cooperate with the physician.* The sick person should seek and follow medical advice. The obligation to get well involves a further obligation on the part of the sick person to seek technically competent help usually from a physician. The sick

person is also expected to cooperate with the physician in the process of trying to get well. Typically, we expect sick people to follow their doctors' recommendations regarding drugs and surgery, and we question the wisdom of those who do not.

In general, Parsons was the first to   demonstrate the function of medicine as a form of social control by incorporating a consideration of health and illness into his analysis of social system.  He did this within the parameters of classical sociological theory.  Parsons' analysis of the sick role moved the study of illness forward by highlighting the social dimensions of illness, including identifying 'illness as deviance' and 'doctors as agents of social control'. It remains important partly because it was the first truly sociological theory of illness. Parsons' research also has proved important because it stimulated later research on interactions between ill people and others.

**The physician-patient role relationship**

 The Physician-patient relationships: The description of a patterned set of expectations that define the norms and values appropriate to being sick in western culture both for  the individual  and for others who  interact  with the sick person is among the major contribution of Parson's concept of the sick  role. The sick role views the interaction between the physician and the patient within a framework of social roles, attitudes, and activities that both parties bring to the situation. Neither the physician nor the patient defines his or her role independently of the role partner.  The full meaning of acting like a physician depends on the patient's conception of what a physician is in terms of the social role. The role of physician in this case is to return the sick person to his or her normal state of function.  Similarly, the role of the patient depends on the conception that the physician holds of the patient's role. Parsons suggests that the patient is expected to recognize that being sick is unpleasant and that he or she has an obligation to get well by seeking the physician's help. Therefore, the patient-doctor relationship is not a spontaneous form of social interaction. It is a well defined encounter consisting of two or more persons whose object is the health of a single individual. Moreover, it is an important situation which would not be left to undefined forms of behavior. Because of this therefore, the patients and physicians tend to act in a stable and predictable manner.

The patient-physician relationship is intended by society to be therapeutic in nature. The patient is in need of technical services from a physician while the physician is a technical expert whom a society defines as a technical expert who is prepared to help a patient. The  goal of the patient –physician encounter is the promotion of significant positive changes for patient's health.  Nonetheless, the status and power relations between the parties involved in the patient –physician relation is not equal though

the relationship is based on the mutuality in the form of behavioral expectations. The role of the physician is based upon an imbalance of power and the technical expertise favorable exclusively to the physician. The imbalance is necessary because the physician needs leverage in his or her relationship with the patient in order to promote positive changes in their patient's health. Accomplishment of this goal may sometimes require procedures that are not comfortable to the patient. Yet, the patient is forced to accept the procedures and follow the treatment plan if physician is to be effective. The physician exercises leverage through three basic techniques: professional prestige, situational authority, and situational dependency of the patient. The professional prestige of a physician comes from the technical qualification as well the certification by a society as a healer. The physician's situational power refers to the fact that physicians are having the knowledge that is believed to relieve the patient. By, contrast, the patient is dependent because he/she lacks the expertise required to treat the health disorder.

**Critiquing the Sick Role Model**

Many recent sociological writing on illness have adopted a **conflict perspective** rather than a functionalist perspective. Whereas functionalists envision society as a harmonious whole held together largely by socialization, mutual consent, and mutual interest, those who hold a conflict perspective argue that society is held together largely by power and coercion, as dominant groups impose their will on others. Consequently, whereas functionalists view deviance as a dysfunctional element to be controlled, conflict theories view deviance as a necessary force for social change and as the conscious or unconscious expression of individuals who refuse to conform to an oppressive society. As a result, conflict theorists have stressed the need to study social control agents as well as, if not more than, the need to study deviants. The conflict perspective has helped sociologists to identify weaknesses in each of the four elements of the sick role model.

Parsons's sick role concept can be criticized from different angles such as behavioral variation, types of diseases, the patient –physician relationship and the sick-role of middle class orientations.

A) Behavioral variation: The criticism of the model by using behavioral variation refers to its lack of uniformity among various persons and social groups. Research findings show that there are distinct and unrelated statuses and complementary role expectations associated with being sick. The other interesting finding which refutes Parsons's model was made by Twaddle. Twaddle's study reveals that the sick role is in part depends on cultural values and whether a person defines himself /herself as "sick". This research found that there were differing definitions of being sick. Moreover, not all of the respondents

stated that they are expected to get well and not all of them cooperated with the physician (Twaddle, 1969 in Cockerheim, 2007).

B) Types of Disease:  The other weakness of Parsons's model is that it seems to apply only to acute diseases. These kind diseases are by their nature temporary, usually recognizable by laypersons and readily overcome with physician's help. However, chronic diseases like diabetes, heart diseases etc are by definition not temporary. Hence, the patient cannot be expected to get well as Parsons's model suggests even though the patient is willing to cooperate with the physician. By implication, temporary exemption from normal role responsibilities for the chronic patient may not be possible. Furthermore, researches on patients with chronic disorders have shown that they perceive the sick role differently from patients with acute illnesses.

C) Patient-physician role relationship: Parsons's model is also criticized for being based on a traditional one -to -one interaction between a patient and a physician. This form of interaction is common because the usual setting is the physician's office where Parsons's version of the sick role is conceptualized. In this setting, the physician has maximum control.  However, different pattern of interaction may emerge where a team of physicians and other members of the hospital staff are involved. In other words, in hospitals, the physician is one of several physicians and his/her behavior is constrained by organizational and health policies. When patients are treated at their home, the patient-physician relationship may take different form because the patient and his or her family can influence the interaction. The other important point is that the pattern of relationship would be modified if the client is seeking preventive techniques rather than strictly therapeutic   measures.

D) Middle-class orientation:  Parson's model is criticized for generalizing middle class pattern of behavior to all patients. The emphasis on individual responsibility and deliberate effort towards good health and normality is believed to be a middle calls orientation.  In addition, many people in the lower socio-economic class may tend to deny the sick role not only because  of the absence of the opportunity to enjoy  typically middle class secondary gains but also owing to the functional  incapacity of the poor person that may render him less  likely  to be able to  earn a living  or survive  in conditions of poverty. Therefore, people living in a poverty environment might work regardless of how sick they might be as long as they feel able to perform some of their work activities. Yet, lower class people may use the sick role to justify their disadvantaged position in a sense they may claim that they are poor because they are sick.

In sum, the sick role model is based on a series of assumptions about both the nature of society and the nature of illness. In addition, the sick role model confuses the experience of patient-hood with the experience of illness (Conrad, 1987). The sick role model focuses on the interaction between the ill person and the mainstream health care system. Yet, interactions with the medical world are from only a small part of the experience of living with illness or disability.

# Chapter Seven:

## Cultural Context of Diseases and Health Care Systems/Settings

**Cultural Context of Illness and Disease**

**Disease Patterns around the World**

In making international comparisons, politicians, social scientists, medical researchers, and others typically divide the world into two broad groups, the industrialized nations and the developing nations, essentially, this division reflects the economic status of the various nations. The industrialized nations are primarily defined by their relatively high gross national product(GNP) per capita compared with developing nations, in addition, the industrialized nations are characterized by diverse economies made up of many different industries, while the developing nations have far simpler economies, in some cases still relying heavily on a few agricultural products such as rubber or bananas, because of these economic differences, the developing nations as a group have higher infant mortality, lower life expectancies, and a greater burden of infection and parasitic diseases than do the industrialized nations.

Although dividing the globe into Industrialized versus developing nations is a useful analytic tool, it is important to remember that development level is a scale, not a dichotomy. So, for example, the most rapidly developing nations like Mexico and Thailand have many complex industries in addition to traditional agricultural crops and enjoy infant mortality rates and life expectancies approaching those found in the United States and Europe. In addition, although infectious and parasitic diseases remain more common in the rapidly developing nations than in the industrialization nations, chronic diseases are now the most common sources of mortality in both sets of nations (Murray and Lopez, 1996). In contrast, in the 31 least developed nations, life expectancy remains less than 50 years and infectious and parasitic diseases skill claim most lives (Population Reference Bureau, 1998).

The division between developing and industrialized nations also should not keep us from recognizing that social conditions and hence health patters vary from community to community and from social group to social group within each nation. Thus conditions in Harlem in some ways resemble those in

Bangladesh, whereas conditions in wealthy sections of Bangkok resemble those in many U.S. cities. Similarly, in the same way that difference in health and access to health care with the United Sates have grown wider in recent years because of general economic policies that have encouraged a growing income gap between rich and poor, differences also have grown in many developing nation because of "structural adjustment" policies adopted by the international Monetary fund, under which developing nations could not get economic aid unless they agreed to cut back social programs such as food subsidies and health care for the poor (Kolko,1999;Peabody,1996)

Finally, although the terms developing and industrialized nations imply linear progression from one status to the other, this is not necessarily the case. For example, economic and health conditions have worsen bed in Eastern European following the collapse of the soviet Union and in parts of Africa as a result of the ADIS epidemic.

With these caveats, the remainder of this chapter explores the sources and nature of disease in the developing nations.  Keep in mind, though, that diseases respect no national borders. With rising globalization; diseases are spreading rapidly from developing to industrialization nations and vice versa. This is especially likely between the United States and Mexico, where only an imaginary line divides two territories that share the same water air and to a large extent, economies. For example, the city of Juarez, Mexico, has no sewage treatment facilities for its pollution of more than one million while neighboring El Paso, Texas, has thousands of homes that lack sanitary septic systems (Skolnick, 1995). As a result, from both sides of the border human wastes drain into the Rio Grande River, which provides water for drinking and for agriculture in these two cities and in downstream communities, including Laredo and Brownsville, Texas. Diseases like cholera or hepatitis could easily take root in these areas and spread into the interiors of both countries. Thus, as this suggests, those whole live in the industrialized nations have a vested interest in understanding health and illness in the developing nations.

**Sources and Nature of Disease in Developing Nations**

**Poverty, Malnutrition and Disease**

The primary factor underlying high death rates and low life expectancies in developing nations is poverty. In the United States, individuals with higher incomes experience less illness and live longer than individuals with lower incomes. In the same way, nations with higher median incomes have lower rates of illness and mortality than nations with lower median incomes. Residents of poor nations die an

average of eleven years earlier than do residents of rich nations (where the per capita GNI averages $20,520).

In large part, poverty causes disease and death by causing chronic malnutrition. According to World Health Organization **(WHO)**, malnutrition accounts for 49 % of deaths before age five in the developing nations (World Health Organization, Programme of Nutrition, 1998). Malnutrition indirectly causes disease and death by damaging the body's immune system, leaving individuals more susceptible to all forms of illness and contributing to both infant and maternal mortality. In addition, malnutrition directly causes numerous health problems including brain damage due to iodine deficiency, blindness due to vitamin A deficiency, and mental retardation due to anemia (World Health Organization, Programme of Nutrition, 1999).

**The Roots of Chronic Malnutrition**

Given the link between malnutrition, illness, and death, the importance of investigating the roots of chronic malnutrition is clear. At first though, one might easily assume that malnutrition in developing nations that have not yet experienced the **epidemiological transition** results naturally from overpopulation combined with insufficient natural and technological resources. Yet food production has surpassed population growth in most countries, including most of those where hunger is common (Lappe et. al, 1998).  In fact, most of the "hungry" countries export more food than they import, and almost every country has access to sufficient food to feed its entire population. Nor can malnutrition be blamed on population density (Lappe et al., 1998). The Netherlands, for example, is one of the most densely populated countries in the world, yet chronic malnutrition no longer occurs there. Similarly, Honduras has twice the cropland per person as Costa Rice, yet malnutrition remains common only in the former. If overpopulation, lack of food, population density, and lack of cropland do not explain chronic malnutrition, what does? The answer lies in the social distribution of food and other resources: malnutrition occurs most often in those countries where resources are most concentrated. In other words, malnutrition occurs not in countries where resources are scare, but in countries where a few people control many resources while many people have access to very few resources (Dreze & Sen, 1989; Lappe et al, 1998; Turshen1989). Similarly, within each country, malnutrition occurs most often among those groups—typically females and the poor—with the least access to resources (Messer, 1997). In essence, then, malnutrition is a disease of powerlessness.

If powerlessness causes malnutrition, then eliminating inequities in power should eliminate malnutrition. Evidence from China and Costa Rica supports this thesis, these two nations—one essentially communist

and one essentially capitalist have both adopted socialistic strategies for redistributing resources some what more equitably. By giving farmland to for merely landless peasants, extending agricultural assistance to owners of small farms, and working to raise the status of women and so on, they have made chronic malnutrition almost unknown within their borders. On the other hand china has not proved immune to acute malnutrition caused by famines. According to Nobel Prize-winning economist Amartya Sen, famines occur when natural events reduce harvests in countries whose non democratic governments need not fear being voted out of office if they do not meet their citizens needs (Sen, 1999).

**The Role of International Aid**

Similarly, international aid—both food aid and development projects—has helped improve the standard of living and health status in developing nations run by democratic governments, but often has had the opposites of fact in non democratic nations(World Bank,1998). Most international food aid comes from the United States, under the 1954 food for Peace Act, or PL480. The primary purpose of this law is to product U.S. economic and military interests (lapped et al., 1998). By sending U.S. farm surpluses overseas as food aid, agricultural produces can maintain prices for their foods at home while opening new markets to U.S. agricultural commodities. In addition, because the United States sells food aid on credit rather than giving it away, food aid helps offset U.S. trade deficits. Food aid also helps to protect U.S. military interests by bolstering the governments of nations with strategic military importance for this country. This explains why U.S. food aid primarily goes not to the hungriest countries, but to countries where the U.S has military interests, such as Egypt, Israel, El Salvador, Pakistan, and Turkey.

Once food aid reaches the developing nations, its distribution can unintentionally reinforce inequities in access to resources and thus malnutrition (Lappe et al., 1998). Food aid goes directly to foreign governments, which can distribute it as they choose, in countries run by democratic governments committed to social equality; aid is likely to benefit those who need it most. Unfortunately manly develop in nations are run by small, economically powerful elites, which sometimes instead sell on the open market any food their governments receive and pocket the profits, thus accentuating social inequities. Because the hungriest people cannot afford to buy food aid sold in the marketplace, food aid dies not improve their nutritional status. In fact, food aid contributes to the malnutrition of the landless tenants, sharecroppers, and day laborers who form the overwhelming bulk of those who suffer from malnutrition (Lappe et al., 1998). When the United States sells its surplus agricultural commodities in the developing nations, the prices of those commodities within the developing nation plummet. As a result, owners of small farms may no longer be able to earn a living and must sell their land to larger

landowners who can take advantage of economies of scale. Thus land ownership and power become further concentrated, as do the inequities that underlie malnutrition and illness in the developing nations. Like international food aide, internationally - sponsored development projects have had mixed impacts on malnutrition and on health in general (World Bank, 1998). According to the politically conservative World Bank, carefully designed projects, sensitive to local conditions and culture and located in countries with democratic governments, open trade, social safety nets, and conservative economic policies can reduce malnutrition and its root causes, in Pakistant, for example, enrollment of girls in schools soared in 1995 when development money was given to local communities to open new schools on the condition that the enrollment rate of girls increased (World Bank, 1998). In the long run, this should increase the status of women, which as we will see, is directly linked to malnutrition, infant mortality, and maternal mortality. On the other hand, projects like the Peligre-Dam in Haiti, the Akonsombo-Dam in Ghana, and the Aswan-Dam is Egypt have brought electricity to urban elites and industrial sites run by multinational corporations while flooding and destroying agricultural fields and rural villages and bringing plagues of waterborne diseases to rural dwellers(Basch,1990; Farmer, 1999). Agricultural development projects have been particularly likely to contribute to malnutrition among women and children (Lapppe et al., 1998). These projects often start from the assumption, based on Western ideas about the family and the economy, that raising cash crops will benefit facilities more than rising food crops and that men rather than women should be responsible for agricultural efforts, however, cultural tradition in many developing nations hold women responsible for growing food and feeding the family (Lappe et al., 1998). When development projects encourage men to grow cash crops the men sometimes take overland women had used to grow food and , because men consider feeding the family a woman's responsibility, use their profits not to purchase food but, rather, to purchase high-status goods for themselves such as tobacco or Western clothes . As a result, malnutrition increases among both women and children.

### *Infectious and Parasitic Diseases*

One result of malnutrition and, more broadly, of poverty is a high rate of infectious and parasitic disease. As stated earlier, such diseases cause the majority of deaths in the least developed nations and still account for considerably more deaths in the rapidly developing nations than in the industrialized nations. As in Europe and the United States before the twentieth century the high rates of infectious and parasitic diseases reflect the dismal circumstances in which many people live. In addition to malnutrition, overcrowding promotes the spread of airborne disease like tuberculosis, while contamination of the

water supply with sewage spreads waterborne diseases such as cholera and intestinal infections. Similarly poor housing and lack of clean water for bathing result in frequent contact with disease spreading rats, fleas, and lice. The infectious and parasitic diseases that most commonly cause deaths in the developing nations are respiratory infections, diarrheal diseases; measles, and malaria. In addition, HIV disease now causes more deaths in central Africa than any other infectious disease.

## *Respiratory Infections*

The most important respiratory infection in the developing world is tuberculosis, which kills between two and three million people yearly (World Health Organization, 1998a). The disease is most common in Asia, followed by Africa and the Middle East, and then by Latin America and the Caribbean. The incidence of tuberculosis is increasing around the world due to the HIV epidemic and the development of drug resistant tuberculosis strains which have made treating that disease economically unfeasible in many developing nations. WHO estimates that HIV causes 1.5 million new tuberculosis cases annually, and that up to 22 percent of persons with tuberculosis in several "hot zones" around the world, including India, Russia, the Dominican Republic, and the Ivory Coast, are infected with multiple drug resistant strains (World Health Organization, 1997a; 1998a).

## *Diarrheal Diseases*

In industrialized nation, diarrhea is generally a source of passing discomfort. In developing nations, diarrheal diseases can be fatal, especially among children under age two (World Health Organization, Division of Child Health and Development, 1992). The World Health Organization estimates that diarrheal diseases kill 4 million children under age five yearly and that children suffering from diarrheal diseases fill more than a third of pediatric hospital beds I some developing nations. Diarrhea is a symptom, not a disease, and can be caused by infection with any of a number of bacterium viruses, or parasites. Diarrhea kills by causing dehydration and electrolytic imbalance. It also leads to malnutrition, as affected children both eat less and absorb fewer nutrients from the foods they eat. In turn, malnutrition leaves children susceptible to other fatal illnesses; conversely, other illnesses can leave children susceptible to both diarrheal diseases and malnutrition.

Diarrheal diseases (which include dysentery, cholera, and infection with E.coli) occur when individuals ingest contaminated water of foods. Consequently, the likelihood of severe diarrhea is greatest when families lack refrigerators, sanitary toilets sufficient fuel to cook foods thoroughly, or safe water for cooking and cleaning. As of 1997, statistics reported to WHO by government officials indicate that 25 % of people living in the developing nations lack access to clean water, down from 39 % a few years

earlier (Kristof,1997). However, these figures many substantially overestimate access as governments may report to WHO that citizens of their countries have access to clean water even if the only water source is a single  sporadically working, faucet, a mile of more away and shared by many families. Survival rates for children with diarrheal diseases in developing nations have improved rapidly in recent years, before the 1960s, those suffering from diarrheal diseases could only be treated using expensive intravenous fluids, making treatment unfeasible for many in the developing nations. Since then, however, scientists have demonstrated that a simple and inexpensive solution of dried salts and water is just as effective, and the World Health Organization has actively and success fully promoted this "oral re-hydration therapy".

### *Measles*

To persons living in the industrialized nations, where measles is considered a minor childhood illness, it might seem odd to see measles listed as a major cause of death. Yet measles kills more children under age five in the developing nations than any other infectious disease –about 1 million children per year (morbidity and Mortality Weekly Report, 1998a.). These deaths occur when children already weakened by malnutrition and poor living conditions, become further weakened by measles, as a result, their bodies ability to fight disease diminishes, leaving them susceptible to potentially deadly pneumonia, respiratory infections, and diarrhea. Unlike tuberculosis and malaria, however, rate of measles declined almost by half during the 1990s as a result of a worldwide measles vaccination campaign run by WHO. Immunization rates have remained unchanged in Africa, however as a result of ongoing and severe economic problems on that continent.

Unfortunately, even if vaccination becomes more widespread and rates of measles continue to decline, the overall health of children in the developing nations will not improve unless social conditions also improve. As long as conditions in the developing nations continue to foster diseases of all kinds, those children who do not die from measles are still likely to die at equally young age's room other diseases; at least one study has found that reducing a country's death rate from measles has no effect on its rate of childhood mortality (Turshen, 1989). Only when the basic inequities in living conditions that underlie death and disease are eliminated or at least substantially reduce will more children survive.

### *Malaria*

More than 40 percent of the world's population lives in areas where malaria is endemic (World Health Organization, Division of Control of Tropical Diseases, 1998). Each year, approximately 300 to 500 million people ( more than 90 % of whom live in tropical Africa) develop malaria, and between 1.5 and

2.7 million people die from the resulting anemia, general debility, or brain infections. Most, however, will survive, but will experience intermittent disabilities from the intermittent chills, fevers, and swats that malaria brings, as a result, looking solely at deaths from malaria under states the true toll malaria imposes on a population's health.

Malaria poses the greatest threat to pregnant women, infants, and young children. Among pregnant women, malaria increases the risks of miscarriage, anemia, and premature labor, each of which increases the risk of potentially fatal hemorrhaging. Infants born to these women typically have lower than average birth weights and, hence higher chances of death or disability. Malaria is often fatal among young children, whose immune systems have not yet developed sufficiently to fight infection; about 90% of those who die from malaria are under age five (World Health Organization, Division of Control Tropical Diseases, 1998).

Malaria is caused by protozoan parasites belonging, to the genus Plasmodium. Malaria is transmitted only by Anopheles mosquitoes and, consequently, exists only where those mosquitoes live. (Anopheles mosquitoes and malaria used to exist throughout the Untied States and appears to be making a comeback; in 1999, for the first time in decades, malaria was diagnosed in a U.S. resident who had neither lived nor traveled in another country.) The disease cycle begins when a mosquito bites an infected individual and ingests the parasite from the individual's blood. The parasite reproduces in the mosquito's stomach and then migrates to the mosquito's stomach and then migrates of the mosquito's salivary glands. The next time the mosquito bites someone, it transmits the parasite to that person.

Because of this transmission cycle, eliminating Anopheles mosquitoes will eliminate malaria. Since the 1940s, ant malaria campaigns have depended heavily on using pesticides to kill mosquitoes. Although these campaigns initially work well, over time the pesticides lose their potency as pesticide resistant mosquitoes evolve, as a result, nations must constantly search for new and ever more toxic pesticides, each of which can endanger birds, fish, and insects that benefit humans. Because of these problems, some recent campaigns have instead focused on encouraging the use of insect repellents, mosquito netting, and screens to prevent infection. These campaigns also have focused on encouraging the use of drugs, such as chloroquine and mefloquine, which can both prevent and treat malaria. Unfortunately, because these drugs can cause debilitating side effects and cost more than many residents of developing nations can afford, infected individuals often stop taking the drugs before they are cured. This continual under treatment of malaria, like the under treatment of tuberculosis, has encouraged the evolution of

drug-resistant strains of the disease around the g lobe, consequently, although malaria has been eliminated in some regions, the situation has worsened during the last decade in the rest of the world.

## *HIV Disease*

More than 90 % of HIV-infected persons in the world live in developing nations (Stine, 1998:361). HIV infection is now endemic in parts of the Caribbean and in much of Africa, and is spreading especially rapidly in Asia (especially in India ad Southeast Asia). From the beginning of the epidemic, heterosexual intercourse has been the major mode of HIV transmission in the developing nations. Consequently, women account for half or more of all cases in these nations. Because many of these countries lack the funds needed to test blood for HIV, transmission via blood transfusions remains common. Similarly, in part because they lack the funds to supply infected women with the drug AZT, which can prevent transmission from mother to fetus, such transmission remains common. (However, the recent development of new, inexpensive drug regiments to prevent transmission could make it less common in future). In faction is most common in urban areas, but is spreading rapidly in the countryside, especially in area where war has disrupted families and increased both consensual and nonconsensual sexual intercours3e between soldiers and villagers. In the hardest hit countries(most located in sub-Saharan Africa), at least 20 % of the entire adult population is infected, while life expectancies have plummeted by 20 or more years (Olshansky et al.,1997).

As stunning g as these numbers might appear they understate the impact of HIV disease, unlike most illnesses, HIV disease most commonly strikes at mid-life, normally the most economically productive years. Moreover, HIV disease disproportionately had affected the most educated segments of the population in the developing nations, consequently, HIV disease has crippled the economy in the hardest hit countries, the resulting increase in unemployment and poverty is sending ripples of illness and death throughout these countries, in addition, HIV disease typically strikes during the childrearing years, as a result, about 16 % of all children in the hardest hit countries have been orphaned, resulting in a second wave of deaths among orphans who have no surviving relatives to care for them (Olshansky et al.,1997).

Several theories have been proposed to explain why HIV disease has hit Africa so hard. The two theories that have gained the most supporters are the cultural theory used by demographer John Caldwell and his colleges and the materialist theory used by sociologist Charles Hunt. Caldwell and his colleagues (1989, 1991, and 1992) have argued that because soils are poor throughout much of Africa, farming there always has been highly labor-intensive, and farming families have needed to have many children to help them in the fields. Consequently, a cultural system developed that valued fertility over chastity or

monogamy and valued ties between parents and children more than ties between spouses. As a result, individuals tended to have relatively high numbers of sexual partners over their lifetimes. In past centuries, Africans typically obtained these sexual partners within small social and geographic circles, since the rise of European colonization, however, and the attendant growth of towns, bars, transportation networks, and, and a commercial sex industry, both the size and geographic spread of African's social circles have broadened, causing dramatic increases in both average numbers of sexual partners and the geographic diversity of those partners, as a result Africans are particularly likely to be exposed to sexually transmitted diseases, including HIV.

Whereas Caldwell and his colleagues five primary emphasis to cultural factors in explaining the devastating rates of HIV disease in Africa, Charles Hunt(1989,1996)emphasis the impact of material conditions. Hunt's argument is based on "world systems theory," which divides the world's nations into core nations, peripheral nations, and a few semi-peripheral nations (Chase-Dunn, 1989; Wallerstein, 1974). The core nations, such as France and the United States, are in effect, an upper class of nations—enjoying a highly diversified, industrialized economy that provides a high standard of living for most citizens. Conversely, the peripheral nations form a lower class of nations, where modernization and industrialization have developed slowly if at all and the standard of living is low for all but small elite.

World systems they argue that the core nations have achieved and maintained their present economic position through exploiting the resources of the peripheral nations, rather than establishing industrials in peripheral nations that would allow those nations to modernize their economics, multinational corporations instead have established industries in the peripheral nations that would allow those nation to modernize their economies, multination corporation instead have established industries in peripheral nations that would allow those nations to modernize their economic, multinational corporations instead have established industries in the peripheral nations based on extracting raw goods, such as rubber, minerals, or specialized food crops, and have brought the profits from those industries back to the core nations, lacking their own modern industries, peripheral nations must buy most manufactured goods and , sometimes, basic foods from the core nations, in this way, the core nations maintain a favorable trade valance with peripheral nations, force the peripheral nations to rely for their economic well being on inherently unstable markets for raw materials, and perpetuate the underclass position of the peripheral nations.

Applying this theory to HIV in Africa, Hunt (1989, 1996) argues that the African nations remain largely under the economic control of corporations based in the former colonial powers. To increase their

profits, those corporations have concentrated industries in a few sites, rather than distributing manufacturing mining, and corporate agriculture around the continent. At traced by the prospects of cash income and faced with few means of earning a living in their home villages, native men leave the countryside to seek emolument at these sites often living apart from their wives and families for weeks, months, or even years at a time. These conditions foster the use of prostitutes and in turn the spread of sexually transmitted diseases, including HIV disease. Once workers become ill, their employers fire them and send them back to their villages, where they spread infection still further. Meanwhile, health conditions also deteriorate among women and children lift in rural villages, the loss of means labor makes it more difficult for women to grow sufficient crops to feed themselves and their children. As a result, women typically adopt agricultural practices and crops that are less labor-intensive, event thought they also deplete the soil and provide less nutrition. Consequently, those left in rural villages grow progressively more malnourished and susceptible to disease. Faced with these conditions, women's only option is to seek employment in cities, where many find prostitution the only available job. This completes the cycle through which multinational corporations indirectly encourage HIV infection among both men and women, in rural and urban areas. Support for this theory comes from data suggesting that HIV was most common and appeared earliest in areas where migrant laborers worked, was next most common in the rural areas from which migrant laborers were recruited, and was least common in areas without links to migrant labor (Hunt, 1998). Other studies similarly have found that economic and structural factors better explain the explosive spread of HIV in Africa than do cultural factors (Simmons et al., 1996). At this point, however, the poor quality of data on HIV rates in African makes it difficult to test any theory with confidence. Moreover, neither the cultural theory used by Caldwell and neither his colleagues nor the materialist theories used by Hunt and others can account fully for the geographic distribution of HIV infection in Africa (Hunt, 1996). Thus, neither theory can be considered fully supported.

### *Infant Mortality*

Like infectious and parasitic diseases, infant mortality is far more common in the developing nations than in the industrialized nations. As of 2001, the average infant mortality rate in the developing nations was 67 per 1,000 live births, eight times higher than the rate in the industrialized nations (Population Reference Bureau, 2002). These averages, however, hide the great range in infant mortality rates within the developing nations.

To understand the sources of infant mortality, we need to differentiate between neonatal infant mortality (during the first twenty-seven days after birth) and post-neonatal infant mortality (between twenty-eight days and eleven months after birth). Rates of neonatal infant mortality, typically caused by genetic defects, do not differ substantially between developing and industrialized nations. Rates of post-neonatal mortality, on the other hand, are far higher in the former countries, especially in the least developed nations, producing significantly higher rates of infant mortality overall. The most common killers of infants in the developing nations are malnutrition and infections (particularly respiratory infections and diarrheal diseases). Because these factors were described earlier in this chapter, in this section, we will focus on two other important sources of post-neonatal infant mortality: women's status and infant formula manufactures.

*The Role of Women's Status:* The low status of women plays a critical role in infant mortality in developing nations. That status "can be readily perceived from the observation that, although women constitute one-third of the world's official labor force, they are responsible for nearly two-thirds of the total hours worked, receive only one-tenth of the world's income, and own less than 1 % of its property" (Basch,1990:24).

Infant mortality occurs most often among babies born with low birth weight. Whereas in the industrialized nations low birth weight typically occurs when babies are born prematurely, in the developing nations, low birth weight typically occurs among babies born after a normal gestation period to mothers who have malaria, are underfed, routinely perform heavy labor, or suffer from anemia, which affects more than 50 % of pregnant women in developing nations (World Health Organization, 1998b). These conditions reflect women's typically low status. Throughout the developing nations, girls and women often spend long hours in heavy labor and, in many nations, receive less nutrition than boys and men (Messer, 1997). In addition, girls are less likely than boys to be immunized against disease, to receive health care when ill, and to receive health care promptly (Messer, 1997). Consequently, girls are more likely to become ill and less likely to survive their illnesses. In Bangladesh, for example, the death rate between the agens of one and four is 58 % greater among girls than among boys (Smyke, 1991:32). Consequently, women often enter their childbearing years already ill and malnourished—a situation that worsens as pregnancies further stress their bodies and drain their energy. Similarly, infant mortality is highest among infants born to very young or very old mothers and to infants born less than eighteen months after a sibling. This occurs most commonly in cultural that expect women to marry at young ages and that judge women's worth by the number of sons they produce. In part, these cultural values

reflect the economic realities of agricultural life: in agricultural societies, children produce more economic resources than they consume, so a family with many children is more likely to succeed than a family with few children. In addition, in the absence of any formal provisions for social security, individuals can only guarantee their security in old age by having sons. (Having daughters usually does not help because daughters in most cultures are expected to take care of their husband's parents rather than their own.)

Nevertheless, even in these societies many women would like to limit their fertility at least some what. This desire is so great that throughout the world, women often choose illegal abortion over childbearing: 44 % of all abortions performed worldwide (and 54 % in developing nations) are illegal (Henshaw et al., 1999). In fact, statistics from Romania, where abortion was outlawed between 1966 and 1989, suggest that making abortion illegal has almost no long term impact on either the abortion rate or the birth rate—although in dramatically increases the number of women who die or become infertile following unsafe abortions (World Health Organization, Division of Reproductive Health,1998). Meanwhile, the slums of Bombay and Rio de Janeiro, like the orphanages of Romania after 1966, are filled with abandoned children whose families could not support them. Similarly, in parts of Asia, infanticide of girl babies continues and abortions now often occur when women learn through genetic testing that they are carrying a female fetus (Banister, 1999).

In sum, research suggests that if women's social status were higher, they would enter their childbearing years with healthier bodies, wait longer to begin having babies, wait longer between babies, and have fewer babies in total, with each of these factors lowering the infant mortality rate. For all these reasons, many researchers and public health workers have suggested that the most effective way to reduce infant mortality is to improve the status of women, thereby increasing their power to make decisions for themselves. This in fact seems to explain at least partly why infant mortality is so much lower in Costa Rica, China, and Zimbabwe than in other countries at similar levels of development.

***The Role of Infant Formula Manufacturers:*** A final cause of infant mortality in the developing nations is the use of artificial foods instead of or in addition to breastfeeding. The benefits are even greater in the developing notions, where babies who receive artificial foods (whether infant formula, juice, water, or any other substances) are twenty-five times more likely than breastfed babies to die from infections (Lancet, 1990). The World Health Organization (1993b) estimates that about one and a half million babies die unnecessarily each year because they are fed artificial foods.

Several factors contribute to the especially high rates of death and disease among artificially fed infants in the developing nations. First, in addition to the inherent limitations of artificial foods, the process of bottle feeding itself can expose infants to tremendous risks. Infant formula is typically sold as a powder that must be mixed with water and then transferred to a bottle before it can be used. In most developing nations, this water contains dangerous infectious organisms. Those organisms can be killed if the water, bottle, and nipple are boiled. However, families do not necessarily understand how or why they should do so. Moreover, throughout the developing nations, women and children already may spend hours each day getting water and firewood and often lack the time and energy to get the extra supplies needed for proper sterilization.

Second, artificial foods cost far more than breast milk (which is not actually free, as it reduces mother's nutritional stores and can prevent their return to paid employment). Consequently, families often stretch the formula by diluting it with water. Babies fed this diluted formula in essence starve to death even while filling their stomachs.

Finally, by altering the hormonal levels in a woman's body, breastfeeding serves as a moderately effective contraceptive. Consequently, breast feeding helps women to space out pregnancies and gives each baby a better chance for survival. For all these reasons, WHO (1995) recommends that children throughout the world, in both industrialized and developing nations, receive only breast milk during the first six months of life and a combination of breast milk and other foods until at least age two.

Given all the benefits of breastfeeding, why do so many women in developing nations instead offer their babies artificial foods? First, of the answer lies in traditional cultural beliefs. For example, some cultures believe that beyond a given age children require certain traditional foods for health. Other cultures indirectly encourage artificial feeding by forbidding sexual relations as long as a woman breastfeeds (Dettwyler, 1995). Second, some women choose to use artificial foods because they cannot mesh breastfeeding with their work whether paid or unpaid. Finally, campaigns by multination food corporations based in the industrialized nations have convinced many women in the developing nations that infant formula is superior to breastfeeding.

To create a market in the developing nations, corporations have provided free or subsidized formula to patients in maternity hospitals (Gerber, 1990; Lancet, 1990). If these women use the formula instead of breastfeeding while in the hospital, they may find it physiologically impossible to switch to breastfeeding later, corporations also have mounted massive advertising campaigns throughout the developing nations to convince women that bottle–feeding produces healthier babies and even lightens

babies' skin - a status symbol in many developing nations. One particularly pernicious strategy is to dress saleswomen as nurses and send them to villages and maternity hospitals to encourage women to bottle-feed.

During the 1970s, recognition of bottle feeding's role in infant mortality led to the rise of an international, consumer-led campaign, based in the United States and Europe, against the multinational corporations that produce infant formula (Gerber, 1990). The campaign focused especially on Nestle, the most aggressive marketer of infant formula in the developing nations. The campaign's main tools were an international awareness campaign and a consumer boycott of infant formula and other products made by Nestle.

In 1981, and partly in response to this campaign, WHO's Assembly adopted an International Code of Marketing of Breast-milk Substitutes aimed at sharply limiting the promotion and sale of formula in the developing nations. (The United States was, the sole nation to vote against the Code, finally ending its opposition only in 1996). Among its provisions, the Code calls for manufacturers to refrain from advertising infant formula, providing free samples to mothers, promoting infant formula through health care facilities, hiring nurses or women dressed as nurses to promote infant formula, providing gifts or personal simplest to health care workers, and providing free or low-cost supplies to hospitals.

By 1984, all the major formula producers had agreed to accept WHO's Code, bringing an end to the boycott, within the developing nations, however, the mistaken notion that bottle –feeding was more "modern" and healthier already had taken root. Moreover, it soon became obvious that the manufacturers, had reneged on their promise to abide by the Code. Consequently, in 1988, the International Baby Food Action Network and Action for Corporate, Accountability, its U.S. affiliate, began a new boycott. Partly as a result of this consumer pressure, billboards and other advertisements for infant formula have become less common and health care workers in developing nations now more often actively support women's efforts to breastfeed. Manufacturers continue to break the code, however, although they now focus more on encouraging mothers to stop breastfeeding early rather than encouraging mothers never to begin (Wise, 1998). A recent study conducted through random sampling in four developing nations found that 10 % of all interviewed mothers with children under six months old and 25 % of all surveyed health care facilities had received free, simplest of bottle-feeding supplies from manufacturers, in direct violation of the WHO Code (Taylor, 1998). Moreover, this survey probably underestimates the problem as it only studied developing nations known for reasonably good compliance with the Code (Costello and Sachev, 1998).

*Maternal Mortality*

Although maternal mortality is now rare in the industrialized nations, it remains the primary cause of death among women of reproductive age in the developing nations. For example, the lifetime risk of dying from childbirth complications is one in 1400 in Europe, one in 65 in Asia, and one in 16 in Africa (World Health Organization, 1998b).

How can we account for the tremendous toll maternal mortality takes in the developing nations? Patricia Smyke, writing for the United Nations (1991:6-62) explains: If you ask, "Why do these women die"? The technical response is: "The main causes of material death are hemorrhage, sepsis (infection), toxemia, obstructed labor and the complications of abortion." But looking beneath those immediate causes, one must ask why they occurred or why they were fatal. The answer to that is: lack of prenatal care: lack of trained personnel, equipment, blood or transport at the moment the obstetrical emergency arose, or earlier, when it might have foreseen and avoided; lack of family planning to help women avoid unwanted pregnancies, too many or too closely spaced birth, or giving birth when they were too young or too old; pre-existing conditions like malaria, anemia, fatigue and malnutrition that predispose to obstetrical complication problems arising from female circumcision. From that list of intermediary causes one must go deeper still to identify the cultural and socioeconomic factors that put young girls, almost from birth, on this road to maternal death:… low status of women and discrimination against them; poverty; lack of education; local customs; and government policies that five low propriety to the needs of women.

Like infant mortality, maternal mortality occurs most often among women who suffer from malnutrition or from illness (most commonly, malaria). Hemorrhage more often occurs during abortion or childbirth in women who develop anemia because of malaria or inadequate diets. Maternal mortality is also most common among women who give birth before age 20 or after age 35. In Bangladesh, for example, where half of all women marry by age 15, maternal mortality is five times higher among those ages 10 to 14 than among those ages 20 to 24 (Basch, 1990). Maternal mortality also rises with each birth after the third. Finally, maternal mortality is more common among women who give birth in unsanitary conditions and among those who have been circumcised.

Another cause of maternal mortality throughout the developing nations is unsafe abortion (Dixon-Mueller, 1990; World Health Organization, Division of Reproductive Health, 1998). Abortion is a technically simple procedure, far safer than childbirth when performed by trained professionals working in sterile conditions with proper tools (World Health Organization, Division of Reproductive Health,

1998). However, most developing nations have criminalized or legally restricted abortion because of cultural traditions, religious beliefs a desire by political elites to increase population, or financial and political pressures from the United States –which since 1973 has withheld family planning funding from any agencies than offer abortions (Dixon Mueller, 1990). In other countries, abortion is legal, but many women cannot afford to obtain abortions from a trained health care worker. Consequently, almost 20 million women yearly—most of whom are married with several children—receive unsafe abortions (World Health Organization, Division of Reproductive Health, 1998). Unsafe abortion accounts for about for about 13 % of maternal mortality in the developing nations, most commonly because of infections caused by un-sterile instrument, hemorrhage when those instruments pierce the uterus, or poisoning when women try to abort themselves by swallowing toxic chemicals. Unsafe abortion can also cause illness or permanent disability. As a result, hospitals in the developing nations spend as much as 50 % of their resources on treating the aftereffects of unsafe abortion (World Health Organization, Division of Reproductive health, 1998).

### *Respiratory Disease*

Finally, respiratory diseases, such as emphysema, are also major killers in the developing nations; the percentage of deaths caused by respiratory disease is almost twice as high in developing nations as in industrialization nations. As with all disease in the developing nations, poverty and malnutrition increase individual susceptibility to illness. In addition, long periods spent cooking over open fires in close rooms expose million of women to cancer-causing toxins that are equivalent to smoking several packs of cigarettes daily. Meanwhile, those who live in cities like Caracas, Mexico City, or Calcutta risk their health daily because of pollution from automobiles and industries. Unfortunately, in some developing nations, government officials lack the political or economic power to control polluting industries and in other nations officials are unwilling to do so because they benefit economically from these industries, equally important, officials in developing nations sometimes believe that population and the attendant morbidity and mortality are short-term costs they must pay to industrialization and to improve their nations' health in the long run.

To these factors must be added the growing role of tobacco which in the developing nations as in the industrialized nations, is a major cause of chronic obstructive pulmonary disease. In addition, tobacco serves as a catalyst that increases the risks of other diseases (World Health Organization 1998c). For example, compared with nonsmokers, smokers who have parasitic bladder infections are more likely to get bladder cancer and smoker who work in uranium mines are more likely to develop leukemia. In

addition, tobacco use promotes disease by taking a large bite out of small incomes, smokers spend as much as 15 % of family income in Brazil and as much as 10 % in India on tobacco; in Egypt wives name their husband's smoking as the main reason their children go hungry (Nichter and Cartwright, 1991). WHO (1998c) estimates that by 2020, tobacco use will cause 11 % of all deaths in developing nations (and 18 % of deaths in industrialized nations).

Tobacco use has gown steadily in the developing nations since 1964, when the U.S. Surgeon General declared tobacco a cause of lung cancer. In response, sales of cigarettes plummet in North America and tobacco manufactures turned to the developing nations for new markets (Hammond, 1998; Nichter and Cartwright, 1991). This tactic proved highly successful: today 37 % of all tobacco users live in the developing nations.

Tobacco manufacturers (most of which are based in the United States have relied on three strategies to increase their sales in the developing nations: heavy advertising, the distribution of tobacco as "food aid," and trade sanctions (Hammond, 1998; Nichter and Cartwright, 1991). Manufacturers have devoted enormous sums to advertising tobacco in the developing nations (Hammond, 1998). In countries where direct advertising of tobacco on television or radio is restricted, manufacturers have marketed their products by sponsoring cultural and athletic events, especially those oriented toward youths. For example, the Chinese national soccer league is now named the "Marlboro Professional Soccer League". U.S. manufacturers also fostered a market for their products in the developing nations by lobbying successfully for inclusion of cigarettes in U.S food aid projects from the 1940s through the 1980s. More recently, responding to efforts by rapidly developing, nations like Thailand to restrict adverting or sales of tobacco, manufacturers have convened the U.S. government to threaten to take sanctions against these nations under the federal 1974 Trade Act and to keep them out of the World Trade Organization (Hammond, 1998). So far, these threats have proved successful.

**Health care systems and the need for reforms**

Health care is a reaction to symptoms and illness which involves decisions on appropriate treatment for a patient that has ranges of possibilities where patients deal with the symptom themselves to obtaining professional help. Health care can be divided into:

- Primary care, taking place in the community as a point of first contact, and
- Secondary care, usually taking place in hospitals and delivered by specialists (Turner, 2006).

- The term tertiary care is sometimes used to indicate rehabilitation, or restorative rather than curative care.

## *Primary versus secondary*

Specialization in health services lead to the emergence of experts for a particular types of illness. This specialization helps patients in finding someone with particular expertise of relevance to their illness. But the problem of prohibitive cost to treat all illness especially minor ones with specialist resources has led health care to be split between primary   and secondary services.

Primary care is generalist and is provided for patients as a point of first contact with health service. The idea that good primary health care is an effective and cheap means of managing most illness has not been lost on financially pressed health care system. There is  now  general encouragement  for doctors to go into  primary health care  and there is  a greater  flow of resources into the sector  to enable  more and more  illness to be treated in this way. On the other, secondary care is a specialist service and usually requires access to bed and often expensive equipment. Because of this feature of secondary care, it is usually based in hospitals.

## Orthodox versus unorthodox

There has been a contention between orthodox and  unorthodox healer. The orthodox healers group professionals specialized in western medicine especially biomedicine. The unorthodox healers are those healers who somehow are sufficiently   different to pose a potential threat to the orthodox ones. The orthodox  protects  its  interests  with  two  strategies  namely  marginalization  and  incorporation. Marginalization  refers  to a  strategy  that  excludes  rival  practitioners  from  regular  medical works by labeling them as inadequately trained in medicine and hence is not legally certified. However, there is a trend in the public interest in unorthodox use of medical care such as acupuncture, homoeopathy, etc.

## Private versus public

This refers to whether health services could be bought in a private negotiation between doctors and a patient  or  provided  as  a  right  free  at  the  point  of  use.  But  this  is  influenced  by  different  political ideologies.

## Alternative healthcare systems

Community care is used to indicate care provided outside institutions, not only by doctors but also by social careers. Preventive care systems (such as immunization) are also distinguished from curative care. The ways in which health care is organized, in  different societies, range from the extreme of a pure market system in which health is treated as  any other commercial commodity, to universal free services

provided entirely by governmental funding. In most nations of the world, however, the distinction is becoming increasingly blurred. A wide range of international studies (notably from the regular publications of the World Health Organization and the Organization for Economic Cooperation and Development) suggest that the way in which services are organized, and indeed the level of provision, have little effect on the health status of populations, once a country has reached an advanced stage of development. This is not because medical services are ineffective, but is thought to be due to the overwhelming weight of other, principally economic and social, factors. Nevertheless, the equity and efficiency of services, patterns of patient usage, and medicine as an institution, are important topics within the sociology of health.

## Types of health care

*Self care:* Due to the quantity of symptoms and illness a person experiences, it is apparent that most of them are treated by self-care. Most patients know how to treat common conditions like minor headache, bad cold etc. They supplement their skills with various pharmaceutical preparations. Self care has advantages in that it allows resources to be devoted to people more in need. This advantage of self care has influenced health service agencies in which they encourage more self care. The use of self care as a strategy by agencies particularly in the areas of disease prevention has clear advantages for a population's health and for the future cost of health services.

*Family care:* The other mechanism used by people to cope with illness is to draw upon the resources of those living around them often of necessity. Relatives, household members and friends can offer support and a form of lay nursing. The typical example is most of childhood illnesses which are treated in this way. This kind of care is usually common in pre-industrial societies. Family care is provided depending on the ability and willingness of household member to take on the task. In addition, family members may be required to take on care if the health care system fails to provide it. Conventionally, the main role of formal healthcare system is to look after people whose illness is very difficult and serious to be managed independently within the home. But the demarcation of very and not difficult depends on the adequacy of resources both within the household and at formal care centers. In family care, the household incurs extra expenses in terms of cleaning, food, special facilities etc. But the largest difficulty is the problem involved in finding someone in the family who can do the caring especially in industrial societies. The role of individual family or household members in looking after another has been recognized in the term "career". Careers are important because they carry a considerable load of the health care that would otherwise fall on the health service.

*Community care:* When family care is less effective for different reasons, the role will be taken by the community. The policy of countries is to encourage home care and support it with more resources from the formal health care system on a community basis. It was the discharge of patients from large mental hospitals that mainly led to the idea of community care in 1950s. The meaning of community care in this context meant care in the community in contrast to care in institutions. Gradually, the idea of care in the community has left the way for care by the community. When adequate resources are mobilized, general practitioners can manage more health problems in the community without the patient being hospitalized. The community or the district nurse can treat problems in the patient's own home which would otherwise have required hospital nursing care. However, several criticisms of community care have been made despite its contributions in relieving the pressures on hospitals and family members. Some of the criticisms are:

- Community care is underfunded. It has been argued that the resources going to community care are inadequate compared to the expenses incurred if the patients were hospitalized. The inadequacy in resources put pressure on family members to bear the cost whenever necessary.

- Community care requires coordination and cooperation between various health as well as welfare agencies which do not often exist. This liaison between general practitioner and social worker for example may not always exist.

- Professional interests may tend to support the status quo in a sense encouraging community care usually means the reallocation of resources away from hospitals and hence, professionals tend to support the preeminence of hospital funding.

- Community care when it means by the community depends on the willingness and ability of the community to cope. The burden of care usually falls on the families especially their women members. By implication, the major difficulty with community care is therefore the fact that it might produce a net saving and reduction in government spending but a comparable ( usually hidden) additional cost falling on the families with illness. Costs are removed from the whole community in terms of government expenditure and placed on individual families with the illness.

*Self help groups:* When some diseases and illnesses pose problems for care self-help groups come to fill the gap. People with some kind of illness may get help from professionals and lay person but the care may not of the right kind. This leads to patients with illness which produces very particular needs to

group together to form their own communities or self help groups. A self help group enables the patient to obtain support and advice from others with similar conditions.

*Professional care*: The professional care is a health care delivered by people in part time or fulltime employment. There are subcategories of professional care. These categories are explained below.

## Evaluating Health Care Systems

### *Universal Coverage*

The most basic measure of any heath care is whether it provides universal coverage, guaranteeing health care to all citizen and legal residents of country. The United state is the only industrialized nation that does not do so. Instead, the U.S government provides insurance to a small percentage of the population, and private insurers have nearly free rein to choose whom they will insure and at what price, in contrast, any legal resident of Great Britain, Canada or Germany, regardless of income, place of residence, employment status, age or any other demographic characteristic, can obtain state-supported health care-although not necessarily everything they want when they want it.

In the absence of universal coverage, uninsured U.S citizens must do without needed care, rely on charity, or hope that they can obtain government-funded health care, when individuals are not eligible for government-funded health care. , hospitals and doctors may provide care, but must make up the financial losses that they incur by raising the prices they change others or "cost shifting." Consequently, from the perspective of the system as a whole, it is more cost-effective to plan to provide care to every who needs it and budget accordingly than to have to find ways to pay for that care after the fact.

### *Portability*

A second important measure of health care system is whether they often portable benefits. As described in the previous chapter, most U.S citizens receive their health insurance through their jobs or their spouse' or parents' jobs. Consequently, individuals can lose their insurance if their families or work situation changes. Similarly, individuals who receive **Medicaid** can lose this coverage if they move to another state or if their income rises above the legal maximum. In contrast, in other developed nations individuals need not worry about losing their insurance no matter what changes occur in their personal lives.

### *Geographic Accessibility*

Even those who have health insurance can face obstacles to receiving care depending on where they live. Both rural areas and poor inner-city neighborhoods in the United States typically have relatively few health care providers per capital. Meanwhile, other areas have an excess of doctors, which can

pressure doctors to increase their prices or perform perhaps unnecessary procedures to maintain their incomes. Consequently, for both economic and medical reasons, we should also evaluate health care systems according to whether they include mechanisms for encouraging an equitable distribution of doctors, such as providing low-cost loans to doctors who work in under-served area or refusing permission for doctors to open practices in over-server areas.

## *Comprehensive Benefits*

Another important measure of health care systems in whether they offer all the essential services individual need. The difficulty, of course, lies in defining what is essential. Although probably all informed observers would agree that comprehensive health care must include coverage for primary care, agreement breaks down quickly once we begin discussing specialty care. Some individuals, for example, consider coronary bypass surgery an essential service, whereas others consider it an overpriced and overhyped luxury. Similarly, some favor offering only procedures necessary to keep patients alive, whereas others support offering only procedures like hip replacement surgery or dental care that improve patients' quality of live even though they don't help patients live any longer. By the same token, some support providing non medical services like home health care and hearing care and hearing aids, whereas others consider purchasing such services an individual responsibility.

Any system that does not provide comprehensive benefits runs the risk devolving into a two-class system, in which some individuals can buy more care than others. To those who believe health care in a human right, such system seems ethically unjustifiable. Others objects to such systems on more practical economic grounds, because, as described earlier, some who cannot afford care eventually seek care anyway, with the costs of that care shifted haphazardly to the rest of the population rather than budgeted in from the start.

## *Affordability*

Guaranteeing access to health care does not help those who cannot afford to purchase it. Consequently, we also must evaluate health care system according to whether they make health care coverage affordable, restraining the costs not only of insurance premiums but also of co-payments, deductibles, and other health care services such as prescription drugs for health care to be affordable, individual costs must parallel individual incomes. As noted earlier, most insured Americans receive their insurance though employers. Employers typically pay a proportion of the costs for premiums and deduct the remainder from individuals' wages. To pay their share of the premiums, employers typically pass their costs on to their employees, dividing the cost equally among all employees and reducing salaries

accordingly (Iglechart, 1999). As a result, low-wages and high-wage workers in essence pay (through reductions in salary) the same dollars amount for their health  insurance imposes a far heavier burden on poorer persons than on wealthier persons; having to pay $3,000

Per year for health insurance, for example, might force wealthier persons to scales back their houses, in contrast, when, as in Great Britain and Canada, health coverage is paid for through graduated income taxes, poorer persons pay a lower percentage of their income for taxes and there fore for health care than wealthier persons. Either way-whether through taxes or lower wages-citizen pay all costs of health care. The only difference is who pay how much.

## *Financial Efficiency*

Another critical measure of a health care system is whether is operates in a financial efficiency manner. Currently, the multitude of private and public insurers in the United States substantially drives up the administrative costs of the health care system. At the same time, the atomized and essentially entrepreneurial nature of our health care system makes it virtually impossible to impose effective cost controls. For example, when the federal government, as described in the last chapter, began paying hospitals prospectively for patients care bases on diagnostic-related groups (DRGs) that established set fees for all patients with the same diagnosis, hospitals kept tier profits high by shifting patients care from inpatient to out patients settings where DRGs did not apply. Similarly, doctors have responded to financial limits on Medicare payments by raising the fees they change to non-Medicare patients. For these reasons, true reform probably must include some mechanism fro simplifying and centralizing control over the health care system and for restraining entrepreneurial element.

## *Consumer Choice*

We also need to evaluate health care systems according to whether they offer consumers a reasonable level of choice. Currently, wealthy Americans can purchase any care they want from any willing provider. In addition, Americans who have fee-for-service insurance can see care from any provider as long as they can afford the co-payments and deductibles and, if their plan uses managed care**,** as long as their insurer approves the care. Those who belong to HMOs, means while, can seek care only from providers affiliated with their plans, unless they have purchased additional coverage and can afford the extra changes. Finally, those who have Medicaid or Medicare coverage can obtain care only from providers willing to accept the relatively low rates of reimbursement offered by these programs, and those who have no health insurance can obtain care only from the few places willing to provide care on charity basis.

No health care system can afford to grand all individual full access to any willing provider. To be acceptable to Americans, however, an alternative health care system probably would need to provide at least the level of consumer choice that HMOs now offer and that many Americans have come to expect.

*Provider Satisfaction*

Finally, for health care system to function smoothly, provider as well as consumers must feel satisfied with the system. Consequently, we must evaluate health care systems according to whether they often health care providers an acceptable level of clinical autonomy, an income commensurate with providers' education and experience, and some control over the nature of their practices.

**Health care settings**

One of the central dilemmas of many countries' including the Ethiopian health care system is how to provide care in profit-driven institutions, as well as in nonprofit institutions that function within a broader, entrepreneurial system. The several settings where people obtain health care include hospitals, nursing homes, board and care homes, assisted living facilities, hospices, and family homes. They are discussed on the American context in the following pages.

*Hospitals Today*

Federal subsidies for hospitals expanded substantially following the implementation in 1969 of **Medicaid and Medicare.** These plans dramatically increased the profits available to hospitals and spurred the merger of hospitals into for-profit and voluntary hospitals chains. As hospital profits grew, so did costs to the federal government via Medicaid and Medicare. As a result, the government for the first time developed a vested interest in controlling hospital costs.

More recent cost-containment programs have especially squeezed funding for public hospitals. Under any circumstances, it is difficult for public hospitals to make ends meet, as about one-third of their patients cannot pay their hospitals bills (Andrulis et al., 1996). Until recently, however public hospitals could subsidize these patients through "disproportionate share funds" given by each state to hospitals that serve a disproportionate share of poor persons.

Concern about costs and profits also has affected the mix of services offered by hospitals.  Hoping to increase profit by offering services that patients would pay for out of pocket (avoiding managed care restrictions altogether), a growing proportion of hospitals now offer alternative therapies such as yoga, meditation, and massage (Abelson and Brown, 2002). Similarly, because insurers ( including Medicare under the DRG system) typically pay only preset amounts for inpatient surgery but give hospitals more leeway in setting  prices for outpatient surgery ( that is, surgery given without formally admitting the

patient to the hospital or requiring on overnight stay), hospitals now offer outpatient surgery whenever technically feasible. At the same time, the competitive market environment has encouraged hospitals to offer new, technologically intensive, treatment even if other nearby hospitals already do so. The result has been a proliferation of technology. Similarly, intensive care units, almost unknown in the 1960s, were found in 66 percent of hospitals by 1998 (American Hospital Association, 1998). As a result of these changes, hospitals now treat an older and sicker mix of patients, most of whom suffer from the acute complications of chronic illnesses. Conversely, as hospitals have shifted toward providing more intensive care for middle – class Americans, some (especially government hospitals) have moved, if unwillingly, toward becoming primary care providers for the poor. Patients who have neither health insurance nor money to pay for care will sometimes turn to hospital outpatient clinics and emergency rooms not only for treatment of acute problems, such as gunshot wounds, but also for chronic problems, such as backaches. This "emergency room abuse," as it is defined by hospitals, aggravates exhausted medical staff and worries hospital administrators concerned about budget. In turn, it has fostered patient dumping, in which voluntary and for-profit hospitals place patients, sometimes in serious medical distress, in ambulances and deliver them to the emergency rooms of government hospitals – often without informing either the patient or the receiving hospitals beforehand. In response to this problem, Congress in 1985 passed the Combined Omnibus Budget reconciliation Act (COBRA), which made it illegal for hospitals to transfer physically unstable patients. This law, however, has not ended the problem.

**The Social Determinants of Health**

A major development in the study of health and disease is the growing recognition of the relevance of social determinants. The term *social determinants of health* refers to social practices and conditions (such as lifestyles, living and work situations), class position (income, education, and occupation), stressful circumstances, poverty, and economic (e.g., unemployment, business recessions), political (e.g., policies, government benefits), and religious factors that affect the health of individuals, groups, and communities, either positively or negatively. Social determinants not only foster illness and disability, they also enhance prospects for coping with or preventing disease and maintaining health. Once thought of as secondary or distant influences on health and disease, it now appears that social connections can be a fundamental cause of health problems (Link and Phelan 1995; Phelan and Link 2013). The social context of a person's life determines the risk of exposure, the susceptibility to a disease, and the course and outcome of the affliction-regardless of whether it is infectious, genetic,

metabolic, malignant, or degenerative (Holtz et al. 2006). Thus, it can be claimed that "society may indeed make you sick or conversely promote your health" (Cockerham

2013a:1).

For example, in addressing the question of whether or not social factors matter to health, the National Research Council and the Institute of Medicine documented various links between social determinants and health (Woolf and Aron 2013). The mostimportant social factors determining health were found to be income, accumulated wealth, education, occupational characteristics, and social inequality based on race and ethnic group. These variables have direct effects on both unhealthy and healthy lifestyles, high or low risk health behavior, and on living conditions, food security, levels of stresses and strains, social disadvantages over the life course, environmental factors that influence biological outcomes through gene expression, and other connections (Cockerham 2005, 2013a, 2013b; Daw et al. 2013; Frohlich and Abel 2014; Goodman, Joyce, and Smith 2011; Phelan and Link 2013; Phelan, Link, and Tehranifar 2010; Miech et al. 2011; Montez and Zajacova 2013; Sandoval and Esteller 2012; Woolf and Aron 2013; Yang et al. 2013).

Social factors are also important in influencing the manner in which societies organize their resources to cope with health hazards and deliver health care to the population at large. Individuals, groups, and societies typically respond to health problems in a manner consistent with their culture, norms, and values. As Donald Light (Light and Schuller 1986:9) explains, "medical care and health services are acts of political philosophy." Thus, social and political values influence the choices made, institutions formed, and levels of funding provided for health. It is no accident that the United States has its particular form of health care delivery and other nations have their own approaches. Health is not simply a matter of biology but involves a number of factors that are cultural, political, economic, and-especially-social in nature. It is the social aspects of health that are examined in this book.